IN LIEU OF FORM CMS-2552-96(04/2005)
PREPARED 5/20/2010 11:22
FORM APPROVED
OMB NO. 0938-0050

THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)). FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE THE BEGINNING OF THE COST REPORT PERIOD BEING DEEMED OVERPAYMENTS (42 USC 1395g).

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO: 14-1327	PERIOD FROM 1/ 1/2009 TO 12/31/2009	INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE 00 - # OF REOPENINGS	DATE RECEIVED: / / INTERMEDIARY NO:

ELECTRONICALLY FILED COST REPORT DATE: 5/20/2010 TIME 11:22

PART I - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED BY THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISIONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
WABASH GENERAL HOSPITAL 14-1327
FOR THE COST REPORTING PERIOD BEGINNING 1/ 1/2009 AND ENDING 12/31/2009 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR ENCRYPTION INFORMATION
DATE: 5/20/2010 TIME 11:22

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qmxHUOCXfW:yB7lw49DDnGXCS2cEdq
7m4:0E3y2GOqTGGF

PI ENCRYPTION INFORMATION
DATE: 5/20/2010 TIME 11:22

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V3y.FOLoJ9Fygtv4YmFXJyk5wopkvj
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OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX	
		1	A 2	B 3	4	
1	HOSPITAL	0	141,314	802,624	0	
3	SWING BED - SNF	0	53,169	0	0	
9	RHC	0	0	2,570	0	
100	TOTAL	0	194,483	805,194	0	

THE ABOVE AMOUNTS REPRESENT "DUE TO" OR "DUE FROM" THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO: 14-1327	PERIOD FROM 1/ 1/2009 TO 12/31/2009	INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE 00 - # OF REOPENINGS	DATE RECEIVED: / / INTERMEDIARY NO:

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OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII A	TITLE XVIII B	TITLE XIX
		1	2	3	4
1	HOSPITAL	0	141,314	802,624	0
3	SWING BED - SNF	0	53,169	0	0
9	RHC	0	0	2,570	0
100	TOTAL	0	194,483	805,194	0

THE ABOVE AMOUNTS REPRESENT "DUE TO" OR "DUE FROM" THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED

Health Financial Systems MCRIF32 FOR WABASH GENERAL HOSPITAL IN LIEU OF FORM CMS-2552-96 (01/2010)

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | PROVIDER NO: 14-1327 | PERIOD: FROM 1/ 1/2009 TO 12/31/2009 | PREPARED 5/20/2010 | WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 1418 COLLEGE DRIVE P.O. BOX:

01 CITY: MT. CARMEL STATE: IL ZIP CODE: 62863- COUNTY: WABASH

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N) V	XVIII	XIX
0	1	2	2.01	3	4	5	6
02.00 HOSPITAL	WABASH GENERAL HOSPITAL	14-1327		6/ 1/2003	N	O	N
04.00 SWING BED - SNF	WABASH GENERAL HOSPITAL SWING BEDS	14-Z327		6/ 1/2003	N	O	N
14.00 HOSPITAL-BASED RHC	WABASH GENERAL RHC	14-8501		4/ 1/2009	N	O	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 1/ 1/2009 TO: 12/31/2009

18 TYPE OF CONTROL — 1: 2

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL — 1

20 SUBPROVIDER

OTHER INFORMATION

21 INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.

21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDENT HOSPITALS)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. — N

21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).

21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY)(SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. — 2: N; Y: 14999

21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL — 2

21.05 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL — 2

21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL; UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA §5105 OR MIPPA §147? (SEE INSTRUC) ENTER "Y" FOR YES, AND "N" FOR NO. — N

21.07 DOES THIS HOSPITAL QUALIFY AS A SCH WITH 100 OR FEWER BEDS UNDER MIPPA §147? ENTER "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)

21.08 WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON S-3, PART I, COL. 5 ENTER IN COLUMN 1, "1" IF IT IS BASED ON DATE OF ADMISSION, "2" IF IT IS BASED ON CENSUS DAYS, OR "3" IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE PRECEEDING COST REPORTING PERIOD? ENTER IN COLUMN 2, "Y" FOR YES OR "N" FOR NO.

22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? — N

23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW. — N

23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. — / / / /

23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. — / / / /

23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. — / / / /

23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. — / / / /

23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE. — / / / /

23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. — / / / /

23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. — / / / /

24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION DATE IN COLUMN 3 (MM/DD/YYYY) — / /

24.01 IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy). — / /

25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R?				N	
01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?					
02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.					
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.				N	
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.				N	
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)					
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)					
26	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH),ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				0	
26.01	ENTER THE APPLICABLE SCH DATES:	BEGINNING: / /	ENDING: / /			
26.02	ENTER THE APPLICABLE SCH DATES:	BEGINNING: / /	ENDING: / /			
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.				Y	6/ 1/2003
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02					

		1	2	3	4
28.01	IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS)	0	0.0000	0.0000	
28.02	ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY	0.00	0		

A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR)

		%	Y/N
28.03	STAFFING	1.00%	Y
28.04	RECRUITMENT	0.00%	
28.05	RETENTION	0.00%	
28.06	TRAINING	0.00%	

	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?				N	
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff)				Y	
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70				N	
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS)				N	
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000).				N	
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II				N	
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).				Y	
31.01	IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).				N	
31.02	IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).				N	
31.03	IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).				N	
31.04	IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).				N	
31.05	IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).				N	

MISCELLANEOUS COST REPORT INFORMATION

32	IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2.				N	
33	IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 2				N	
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA?				N	
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?				N	
35.01	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?				N	
35.02	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?					
03	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?					
04	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?					

		V	XVIII	XIX
	SPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL	1	2	3
	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	N	N	N
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.320? (SEE INSTRUCTIONS)	N	N	N
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	N	N	N
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE?			

TITLE XIX INPATIENT SERVICES			
38	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?	Y	
38.01	IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?	N	
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	N	
38.03	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?	N	
38.04	DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	N	
40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10? IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COLUMN 2 THE CHAIN HOME OFFICE CHAIN NUMBER. (SEE INSTRUCTIONS).	N		
40.01	NAME: FI/CONTRACTOR NAME		FI/CONTRACTOR #	
40.02	STREET: P.O. BOX:			
40.03	CITY: STATE: ZIP CODE: -			
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N		
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N		
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N		
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N		
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY?	N		
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.	N	00/00/0000	
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?			
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?			
45.03	WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?			
46	IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).			

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES, ENTER "Y" FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION. ENTER "N" IF NOT EXEMPT. (SEE 42 CFR 413.13.)

	PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC
	1	2	3	4	5
00	HOSPITAL N	N	N	N	N

52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS)	N	
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV	N	
53	IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	0	
53.01	MDH PERIOD: BEGINNING: / / ENDING: / /		
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:		
	PREMIUMS:	0	
	PAID LOSSES:	0	
	AND/OR SELF INSURANCE:	0	
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N	
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO.	N	

		DATE	Y OR N	LIMIT	Y OR N	FEES
		0	1	2	3	4
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.		Y	0.00	N	0
56.01	ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE.			0.00		0
56.02	THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0
56.03	FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0

57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?	N
	ARE YOU AN INPATIENT REHABILITATION FACILITY(IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.	N
58.01	IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y"FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR).	0
59	ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)	N
60	ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)	N
60.01	IF LINE 60 COLUMN 1 IS Y, AND THE FACILITY IS AN IPF SUBPROVIDER, WERE RESIDENTS TRAINING IN THIS FACILITY IN ITS MOST RECENT COST REPORTING PERIOD FILED BEFORE NOV. 15, 2004? ENTER "Y" FOR YES AND "N" FOR NO. IS THIS FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(C)? ENTER IN COL. 2 "Y" FOR YES OR "N" FOR NO. IF COL. 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COL. 3, (SEE INSTRUC). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COL. 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUC).	0

MULTICAMPUS

61.00 IS THIS FACILITY PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSA? ENTER "Y" FOR YES AND "N" FOR NO.

IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL.2, ZIP IN COL 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.

	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00						0.00

SETTLEMENT DATA

.00 WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER "Y" FOR YES AND "N" FOR NO IN COL. 1. IF COL. 1 IS "Y", ENTER THE "PAID THROUGH" DATE OF THE PS&R IN COL. 2 (MM/DD/YYYY). / /

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

PROVIDER NO: 14-1327 | PERIOD: FROM 1/ 1/2009 TO 12/31/2009 | PREPARED 5/20/2010 | WORKSHEET S-3 | PART I

	COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	I/P DAYS / O/P VISITS / TRIPS: TITLE V 3	TITLE XVIII 4	NOT LTCH N/A 4.01	TOTAL TITLE XIX 5
1	ADULTS & PEDIATRICS	21	7,665	60,408.00		1,933		113
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF					362		
4	ADULTS & PED-SB NF							37
5	TOTAL ADULTS AND PEDS	21	7,665	60,408.00		2,295		150
6	INTENSIVE CARE UNIT	4	1,460	2,448.00		53		7
12	TOTAL	25	9,125	62,856.00		2,348		157
13	RPCH VISITS							
24	RURAL HEALTH CLINIC					187		
25	TOTAL	25						
26	OBSERVATION BED DAYS							109
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

	COMPONENT	I/P DAYS / TRIPS: TITLE XIX OBSERVATION BEDS ADMITTED 5.01	NOT ADMITTED 5.02	O/P VISITS TOTAL ALL PATS 6	TRIPS: TOTAL OBSERVATION BEDS ADMITTED 6.01	NOT ADMITTED 6.02	INTERNS & RES. FTES: TOTAL 7	LESS I&R REPL NON-PHYS ANES 8
1	ADULTS & PEDIATRICS			2,517				
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF			362				
4	ADULTS & PED-SB NF			37				
5	TOTAL ADULTS AND PEDS			2,916				
6	INTENSIVE CARE UNIT			102				
12	TOTAL			3,018				
13	RPCH VISITS							
24	RURAL HEALTH CLINIC			3,367				
25	TOTAL							
26	OBSERVATION BED DAYS		109	948		948		
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

	COMPONENT	I & R FTES: NET 9	FULL TIME EQUIV: EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	DISCHARGES: TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1	ADULTS & PEDIATRICS					514	40	720
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS							
6	INTENSIVE CARE UNIT							
12	TOTAL		187.53			514	40	720
13	RPCH VISITS							
24	RURAL HEALTH CLINIC		1.42					
25	TOTAL		188.95					
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER PROVIDER STATISTICAL DATA

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1327	FROM 1/ 1/2009	WORKSHEET S-8
COMPONENT NO:	TO 12/31/2009	
14-8501		

RHC 1

NIC ADDRESS AND IDENTIFICATION

1 STREET: 1418 COLLEGE DRIVE

1.01 CITY: MT.CARMEL STATE: IL ZIP CODE: 62863 COUNTY: WABASH

2 DESIGNATION (FOR FQHCS ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN R

SOURCE OF FEDERAL FUNDS:	GRANT AWARD 1	DATE 2
3 COMMUNITY HEALTH CENTER (SECTION 339(d), PHS ACT)		/ /
4 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)		/ /
5 HEALTH SERVICES FOR THE HOMELESS (SECTION 340(d), PHS ACT)		/ /
6 APPALACHIAN REGIONAL COMMISSION		/ /
7 LOOK-ALIKES		/ /
8 OTHER (SPECIFY)		/ /

PHYSICIAN INFORMATION:	PHYSICIAN NAME	BILLING NUMBER
9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT		

	PHYSICIAN NAME	HOURS OF SUPERVISION
10 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD		

11 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2 (ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS.) N

FACILITY HOURS OF OPERATIONS (1)

	TYPE OPERATION	SUNDAY FROM	SUNDAY TO	MONDAY FROM	MONDAY TO	TUESDAY FROM	TUESDAY TO	WEDNESDAY FROM	WEDNESDAY TO	THURSDAY FROM	THURSDAY TO	FRIDAY FROM	FRIDAY TO	SATURDAY FROM	SATURDAY TO
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
12	CLINIC	1200	2100	1800	2100	1800	2100	1800	2100	1800	2100	1800	2100	1200	2100

(1) ENTER CLINIC HOURS OF OPERATIONS ON SUBSCRIPTS OF LINE 12 (BOTH TYPE AND HOURS OF OPERATION). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400

13 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? N

14 IS THIS A CONSOLIDATED COST REPORT DEFINED IN THE RURAL HEALTH CLINIC MANUAL? IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS INCLUDED IN THIS REPORT, COMPLETE LINE 15 AND COMPLETE ONLY ONE WORKSHEET SERIES M FOR THE CONSOLIDATED GROUP. IF NO, COMPLETE A SEPARATE WORKSHEET S-8 FOR EACH COMPONENT ACCOMPANIED BY A CORRESPONDING WORKSHEET M SERIES. N

15 PROVIDER NAME: PROVIDER NUMBER:

	TITLE V	TITLE XVIII	TITLE XIX
16 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS & RESIDENTS.	N		

17 HAS THE HOSPITALS' BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? IF YES, SEE INSTRUCTIONS. N

HOSPITAL UNCOMPENSATED CARE DATA

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1327	FROM 1/ 1/2009	WORKSHEET S-10
	TO 12/31/2009	

	DESCRIPTION	
	UNCOMPENSATED CARE INFORMATION	
1	DO YOU HAVE A WRITTEN CHARITY CARE POLICY?	
2	ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER LINES 2.01 THRU 2.04	
2.01	IS IT AT THE TIME OF ADMISSION?	
2.02	IS IT AT THE TIME OF FIRST BILLING?	
2.03	IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE?	
2.04		
3	ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS?	
4	ARE CHARITY DETERMINATIONS BASED UPON ADMINISTRATIVE JUDGMENT WITHOUT FINANCIAL DATA?	
5	ARE CHARITY DETERMINATIONS BASED UPON INCOME DATA ONLY?	
6	ARE CHARITY DETERMINATIONS BASED UPON NET WORTH (ASSETS) DATA?	
7	ARE CHARITY DETERMINATIONS BASED UPON INCOME AND NET WORTH DATA?	
8	DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD DEBT AND CHARITY CARE? IF YES ANSWER 8.01	
8.01	DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT SERVICES?	
9	IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04	
9.01	IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE ELIGIBILITY?	
9.02	IS IT BECAUSE THERE IS NO FINANCIAL INCENTIVE TO SEPARATE CHARITY FROM BAD DEBT?	
9.03	IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON CHARITY DETERMINATION?	
9.04	IS IT BECAUSE YOUR INSTITUTION DOES NOT DEEM THE DISTINCTION IMPORTANT?	
10	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS (SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO BE A CHARITY WRITE OFF?	
11	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY LEVEL? IF YES ANSWER 11.01 THRU 11.04	
11.01	IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL POVERTY LEVEL?	
11.02	IS THE PERCENTAGE LEVEL USED BETWEEN 100% AND 150% OF THE FEDERAL POVERTY LEVEL?	
11.03	IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200% OF THE FEDERAL POVERTY LEVEL?	
11.04	IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF THE FEDERAL POVERTY LEVEL?	
12	ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME PATIENTS ON A GRADUAL SCALE?	
13	IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY MEDICAL EXPENSES?	
14	IS YOUR HOSPITAL STATE OR LOCAL GOVERNMENT OWNED? IF YES ANSWER LINES 14.01 AND 14.02	
14.01	DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THAT GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING COMPENSATED CARE?	
14.02	WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM GOVERNMENT FUNDING?	
15	DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE TO CHARITY PATIENTS?	
16	ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE CHARITY CARE?	
	UNCOMPENSATED CARE REVENUES	
17	REVENUE FROM UNCOMPENSATED CARE	153,539
17.01	GROSS MEDICAID REVENUES	3,307,398
18	REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS	
19	REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS)	
20	RESTRICTED GRANTS	
21	NON-RESTRICTED GRANTS	
22	TOTAL GROSS UNCOMPENSATED CARE REVENUES	3,460,937
	UNCOMPENSATED CARE COST	
23	TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL INDIGENT CARE PROGRAMS	
24	COST TO CHARGE RATIO (WKST C, PART I, COLUMN 3, LINE 103, DIVIDED BY COLUMN 8, LINE 103)	.415299
25	TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST (LINE 23 * LINE 24)	
26	TOTAL SCHIP CHARGES FROM YOUR RECORDS	
27	TOTAL SCHIP COST, (LINE 24 * LINE 26)	
28	TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS	3,307,398

HOSPITAL UNCOMPENSATED CARE DATA

PROVIDER NO: 14-1327 PERIOD: FROM 1/ 1/2009 TO 12/31/2009 PREPARED 5/20/2010 WORKSHEET S-10

	DESCRIPTION	
29	TOTAL GROSS MEDICAID COST (LINE 24 * LINE 28)	1,373,559
30	OTHER UNCOMPENSATED CARE CHARGES FROM YOUR RECORDS	
31	UNCOMPENSATED CARE COST (LINE 24 * LINE 30)	
32	TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL (SUM OF LINES 25, 27, AND 29)	1,373,559

Health Financial Systems MCRIF32 FOR WABASH GENERAL HOSPITAL IN LIEU OF FORM CMS-2552-96(9/1996)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: 14-1327 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET A

	COST CENTER	COST CENTER DESCRIPTION	SALARIES	OTHER	TOTAL	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE
			1	2	3	4	5
		GENERAL SERVICE COST CNTR					
3	0300	NEW CAP REL COSTS-BLDG & FIXT		409,425	409,425		409,425
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		474,264	474,264	651,500	1,125,764
5	0500	EMPLOYEE BENEFITS	122,526	3,175,797	3,298,323	-90	3,298,233
6	0600	ADMINISTRATIVE & GENERAL	787,611	2,102,858	2,890,469	52,201	2,942,670
8	0800	OPERATION OF PLANT	159,943	566,076	726,019		726,019
10	1000	HOUSEKEEPING	217,959	46,158	264,117		264,117
11	1100	DIETARY	232,448	192,624	425,072	-264,443	160,629
12	1200	CAFETERIA				263,454	263,454
14	1400	NURSING ADMINISTRATION	133,385	7,989	141,374		141,374
17	1700	MEDICAL RECORDS & LIBRARY	262,245	39,120	301,365		301,365
18	1800	SOCIAL SERVICE	91,866	23,213	115,079	-8,688	106,391
20	2000	NONPHYSICIAN ANESTHETISTS	380,866	56,875	437,741	-3,068	434,673
		INPAT ROUTINE SRVC CNTRS					
25	2500	ADULTS & PEDIATRICS	1,123,035	354,634	1,477,669	-59,542	1,418,127
26	2600	INTENSIVE CARE UNIT	225,805	43,935	269,740	-35,194	234,546
		ANCILLARY SRVC COST CNTRS					
37	3700	OPERATING ROOM	534,038	269,311	803,349	-48,030	755,319
40	4000	ANESTHESIOLOGY					
41	4100	RADIOLOGY-DIAGNOSTIC	568,306	860,753	1,429,059	-164,545	1,264,514
44	4400	LABORATORY	627,288	615,042	1,242,330	-62,900	1,179,430
49	4900	RESPIRATORY THERAPY	348,445	170,453	518,898	-8,961	509,937
50	5000	PHYSICAL THERAPY	458,065	34,169	492,234	-1,306	490,928
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS	95,012	1,423,229	1,518,241	203,220	1,721,461
56	5600	DRUGS CHARGED TO PATIENTS	286,505	1,218,007	1,504,512	-4,830	1,499,682
59	3480	ONCOLOGY	169,273	157,591	326,864	-20,956	305,908
		OUTPAT SERVICE COST CNTRS					
60	6000	CLINIC	14,560	10,026	24,586		24,586
61	6100	EMERGENCY	875,470	1,422,426	2,297,896	-47,663	2,250,233
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950	OTHER OUTPATIENT SERVICE COST CENTER					
63.50	6310	RURAL HEALTH CLINIC	121,887	3,144	125,031		125,031
		OTHER REIMBURS COST CNTRS					
65	6500	AMBULANCE SERVICES	416,727	76,357	493,084	-17,930	475,154
		SPEC PURPOSE COST CENTERS					
88	8800	INTEREST EXPENSE		422,229	422,229	-422,229	
95		SUBTOTALS	8,253,265	14,175,705	22,428,970	-0-	22,428,970
		NONREIMBURS COST CENTERS					
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN					
98	9800	PHYSICIANS' PRIVATE OFFICES	1,982,218	872,426	2,854,644		2,854,644
99		TOTAL	10,235,483	15,048,131	25,283,614	-0-	25,283,614

	COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
			6	7
		GENERAL SERVICE COST CNTR		
3	0300	NEW CAP REL COSTS-BLDG & FIXT		409,425
4	0400	NEW CAP REL COSTS-MVBLE EQUIP	-40,264	1,085,500
5	0500	EMPLOYEE BENEFITS		3,298,233
6	0600	ADMINISTRATIVE & GENERAL	-408,435	2,534,235
8	0800	OPERATION OF PLANT		726,019
10	1000	HOUSEKEEPING		264,117
11	1100	DIETARY	-2,124	158,505
12	1200	CAFETERIA	-75,592	187,862
14	1400	NURSING ADMINISTRATION		141,374
17	1700	MEDICAL RECORDS & LIBRARY	-8,319	293,046
18	1800	SOCIAL SERVICE		106,391
20	2000	NONPHYSICIAN ANESTHETISTS	-380,866	53,807
		INPAT ROUTINE SRVC CNTRS		
25	2500	ADULTS & PEDIATRICS		1,418,127
26	2600	INTENSIVE CARE UNIT		234,546
		ANCILLARY SRVC COST CNTRS		
37	3700	OPERATING ROOM	-189	755,130
40	4000	ANESTHESIOLOGY		
41	4100	RADIOLOGY-DIAGNOSTIC	-5,058	1,259,456
44	4400	LABORATORY	-6,000	1,173,430
49	4900	RESPIRATORY THERAPY	-91,003	418,934
50	5000	PHYSICAL THERAPY		490,928
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS	-2,613	1,718,848
56	5600	DRUGS CHARGED TO PATIENTS	-30,791	1,468,891
59	3480	ONCOLOGY	-103,000	202,908
		OUTPAT SERVICE COST CNTRS		
60	6000	CLINIC		24,586
61	6100	EMERGENCY	-954,569	1,295,664
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)		
63	4950	OTHER OUTPATIENT SERVICE COST CENTER		
63.50	6310	RURAL HEALTH CLINIC		125,031
		OTHER REIMBURS COST CNTRS		
65	6500	AMBULANCE SERVICES		475,154
		SPEC PURPOSE COST CENTERS		
88	8800	INTEREST EXPENSE		-0-
95		SUBTOTALS	-2,108,823	20,320,147
		NONREIMBURS COST CENTERS		
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN		
98	9800	PHYSICIANS' PRIVATE OFFICES		2,854,644
01		TOTAL	-2,108,823	23,174,791

Health Financial Systems MCRIF32 FOR WABASH GENERAL HOSPITAL IN LIEU OF FORM CMS-2552-96(7/2009)

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I 14-1327 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I NOT A CMS WORKSHEET I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
20	NONPHYSICIAN ANESTHETISTS	2000	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
59	ONCOLOGY	3480	ONCOLOGY
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63	OTHER OUTPATIENT SERVICE COST CENTER	4950	OTHER OUTPATIENT SERVICE COST CENTER
63.50	RURAL HEALTH CLINIC	6310	RURAL HEALTH CLINIC #####
	OTHER REIMBURS COST		
65	AMBULANCE SERVICES	6500	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
98	PHYSICIANS' PRIVATE OFFICES	9800	
`1	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

	EXPLANATION OF RECLASSIFICATION	CODE (1) 1	COST CENTER 2	LINE NO 3	INCREASE SALARY 4	INCREASE OTHER 5
1	RENT	A	NEW CAP REL COSTS-MVBLE EQUIP	4		229,271
2						
3						
4						
5						
6						
7						
8						
9						
10	CAFETERIA	B	CAFETERIA	12	144,068	119,386
11	IV SOLUTIONS	C	DRUGS CHARGED TO PATIENTS	56		5,738
12	MATERIAL MANAGEMENT	D	ADMINISTRATIVE & GENERAL	6		52,247
13	INTEREST	E	NEW CAP REL COSTS-MVBLE EQUIP	4		422,229
14	OXYGEN	F	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		5,670
15						
16						
17	MED SUPPLIES	G	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		255,535
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
36	TOTAL RECLASSIFICATIONS				144,068	1,090,076

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.
See instructions for column 10 referencing to Worksheet A-7, Part III, columns 9 through 14.

	EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	LINE NO	DECREASE SALARY	DECREASE OTHER	A-7 REF
		1	6	7	8	9	10
1	RENT	A	EMPLOYEE BENEFITS	5		90	10
2			DIETARY	11		989	
3			SOCIAL SERVICE	18		8,688	
4			INTENSIVE CARE UNIT	26		31,668	
5			RADIOLOGY-DIAGNOSTIC	41		151,600	
6			LABORATORY	44		22,610	
7			RESPIRATORY THERAPY	49		1,580	
8			AMBULANCE SERVICES	65		12,000	
9			ADMINISTRATIVE & GENERAL	6		46	
10	CAFETERIA	B	DIETARY	11	144,068	119,386	
11	IV SOLUTIONS	C	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		5,738	
12	MATERIAL MANAGEMENT	D	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		52,247	
13	INTEREST	E	INTEREST EXPENSE	88		422,229	11
14	OXYGEN	F					
15			RESPIRATORY THERAPY	49		4,772	
16			AMBULANCE SERVICES	65		898	
17	MED SUPPLIES	G	NONPHYSICIAN ANESTHETISTS	20		3,068	
18			ADULTS & PEDIATRICS	25		59,542	
19			INTENSIVE CARE UNIT	26		3,526	
20			OPERATING ROOM	37		48,030	
21			RADIOLOGY-DIAGNOSTIC	41		12,945	
22			LABORATORY	44		40,290	
23			RESPIRATORY THERAPY	49		2,609	
24			PHYSICAL THERAPY	50		1,306	
25			ONCOLOGY	59		20,956	
26			EMERGENCY	61		47,663	
27			AMBULANCE SERVICES	65		5,032	
28			DRUGS CHARGED TO PATIENTS	56		10,568	
36	TOTAL RECLASSIFICATIONS				144,068	1,090,076	

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.
See instructions for column 10 referencing to Worksheet A-7, Part III, columns 9 through 14.

RECLASS CODE: A
EXPLANATION : RENT

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	229,271	EMPLOYEE BENEFITS	5	90
2.00			0	DIETARY	11	989
3.00			0	SOCIAL SERVICE	18	8,688
4.00			0	INTENSIVE CARE UNIT	26	31,668
5.00			0	RADIOLOGY-DIAGNOSTIC	41	151,600
6.00			0	LABORATORY	44	22,610
7.00			0	RESPIRATORY THERAPY	49	1,580
8.00			0	AMBULANCE SERVICES	65	12,000
9.00			0	ADMINISTRATIVE & GENERAL	6	46
TOTAL RECLASSIFICATIONS FOR CODE A			229,271			229,271

RECLASS CODE: B
EXPLANATION : CAFETERIA

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	CAFETERIA	12	263,454	DIETARY	11	263,454
TOTAL RECLASSIFICATIONS FOR CODE B			263,454			263,454

RECLASS CODE: C
EXPLANATION : IV SOLUTIONS

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	DRUGS CHARGED TO PATIENTS	56	5,738	MEDICAL SUPPLIES CHARGED TO PA	55	5,738
TOTAL RECLASSIFICATIONS FOR CODE C			5,738			5,738

RECLASS CODE: D
EXPLANATION : MATERIAL MANAGEMENT

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	52,247	MEDICAL SUPPLIES CHARGED TO PA	55	52,247
TOTAL RECLASSIFICATIONS FOR CODE D			52,247			52,247

RECLASS CODE: E
EXPLANATION : INTEREST

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	422,229	INTEREST EXPENSE	88	422,229
TOTAL RECLASSIFICATIONS FOR CODE E			422,229			422,229

RECLASS CODE: F
EXPLANATION : OXYGEN

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	5,670			0
3.00			0	RESPIRATORY THERAPY	49	4,772
4.00			0	AMBULANCE SERVICES	65	898
TOTAL RECLASSIFICATIONS FOR CODE F			5,670			5,670

RECLASS CODE: G
EXPLANATION : MED SUPPLIES

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	255,535	NONPHYSICIAN ANESTHETISTS	20	3,068
2.00			0	ADULTS & PEDIATRICS	25	59,542
3.00			0	INTENSIVE CARE UNIT	26	3,526
4.00			0	OPERATING ROOM	37	48,030
5.00			0	RADIOLOGY-DIAGNOSTIC	41	12,945
6.00			0	LABORATORY	44	40,290
7.00			0	RESPIRATORY THERAPY	49	2,609
8.00			0	PHYSICAL THERAPY	50	1,306
9.00			0	ONCOLOGY	59	20,956
11.00			0	EMERGENCY	61	47,663
12.00			0	AMBULANCE SERVICES	65	5,032

RECLASS CODE: G
EXPLANATION : MED SUPPLIES

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
13.00			0	DRUGS CHARGED TO PATIENTS	56	10,568
TOTAL RECLASSIFICATIONS FOR CODE G			255,535			255,535

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS			DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS
			PURCHASES	DONATION	TOTAL			
		1	2	3	4	5	6	7
1	LAND							
2	LAND IMPROVEMENTS							
3	BUILDINGS & FIXTURE							
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT							
7	SUBTOTAL							
8	RECONCILING ITEMS							
9	TOTAL							

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS			DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS
			PURCHASES	DONATION	TOTAL			
		1	2	3	4	5	6	7
1	LAND	166,949	249,918		249,918		416,867	
2	LAND IMPROVEMENTS	509,682	34,169		34,169		543,851	
3	BUILDINGS & FIXTURE	12,766,282	401,587		401,587		13,167,869	
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT	1,334,107	1,680,436		1,680,436		3,014,543	
6	MOVABLE EQUIPMENT	6,625,207	1,109,705		1,109,705		7,734,912	
7	SUBTOTAL	21,402,227	3,475,815		3,475,815		24,878,042	
8	RECONCILING ITEMS							
9	TOTAL	21,402,227	3,475,815		3,475,815		24,878,042	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS GROSS ASSETS	CAPITLIZED GROSS ASSETS LEASES	FOR RATIO	RATIO	ALLOCATION OF OTHER CAPITAL INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	TOTAL
*		1	2	3	4	5	6	7	8
3	NEW CAP REL COSTS-BL	14,777,021		14,777,021	.690443				
4	NEW CAP REL COSTS-MV	6,625,207		6,625,207	.309557				
5	TOTAL	21,402,228		21,402,228	1.000000				

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	409,425						409,425
4	NEW CAP REL COSTS-MV	434,000	229,271	422,229				1,085,500
5	TOTAL	843,425	229,271	422,229				1,494,925

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	409,425						409,425
4	NEW CAP REL COSTS-MV	474,264						474,264
5	TOTAL	883,689						883,689

* All lines numbers except line 5 are to be consistent with Workhseet A line numbers for capital cost centers.
(1) The amounts on lines 1 thru 4 must equal the corresponding amounts on Worksheet A, column 7, lines 1 thru 4.
Columns 9 through 14 should include related Worksheet A-6 reclassifications and Worksheet A-8 adjustments. (See instructions).

Health Financial Systems MCRIF32 FOR WABASH GENERAL HOSPITAL IN LIEU OF FORM CMS-2552-96(05/1999)

ADJUSTMENTS TO EXPENSES

I PROVIDER NO: 14-1327 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET A-8

	DESCRIPTION (1)	(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO 4	WKST. A-7 REF. 5
1	INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
2	INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3	INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
4	INVESTMENT INCOME-NEW MOVABLE EQUIP	B	-40,264	NEW CAP REL COSTS-MVBLE E	4	9
5	INVESTMENT INCOME-OTHER					
6	TRADE, QUANTITY AND TIME DISCOUNTS	B	-9,965	ADMINISTRATIVE & GENERAL	6	
7	REFUNDS AND REBATES OF EXPENSES					
8	RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9	TELEPHONE SERVICES					
10	TELEVISION AND RADIO SERVICE					
11	PARKING LOT					
12	PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-1,159,630			
13	SALE OF SCRAP, WASTE, ETC.					
14	RELATED ORGANIZATION TRANSACTIONS	A-8-1				
15	LAUNDRY AND LINEN SERVICE					
16	CAFETERIA--EMPLOYEES AND GUESTS	B	-75,592	CAFETERIA	12	
17	RENTAL OF QTRS TO EMPLYEE AND OTHRS					
18	SALE OF MED AND SURG SUPPLIES	B	-2,613	MEDICAL SUPPLIES CHARGED	55	
19	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-30,791	DRUGS CHARGED TO PATIENTS	56	
20	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-8,319	MEDICAL RECORDS & LIBRARY	17	
21	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22	VENDING MACHINES					
23	INCOME FROM IMPOSITION OF INTEREST					
24	INTRST EXP ON MEDICARE OVERPAYMENTS					
25	ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26	ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27	ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28	UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**	89	
29	DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
30	DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
31	DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
32	DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	20	
34	PHYSICIANS' ASSISTANT					
35	ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**	51	
36	ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		**COST CENTER DELETED**	52	
37	DIETARY	B	-2,124	DIETARY	11	
38						
39	MISCELLANEOUS	B	-79,632	ADMINISTRATIVE & GENERAL	6	
40	PHYSICIAN RECRUITMENT	A	-124,822	ADMINISTRATIVE & GENERAL	6	
41	PUBLIC RELATIONS	A	-194,016	ADMINISTRATIVE & GENERAL	6	
42	DR AKINTAN	B	-189	OPERATING ROOM	37	
43	CRNA	A	-380,866	NONPHYSICIAN ANESTHETISTS	20	
44						
45						
46	OTHER ADJUSTMENTS (SPECIFY)					
47	OTHER ADJUSTMENTS (SPECIFY)					
48	OTHER ADJUSTMENTS (SPECIFY)					
49	OTHER ADJUSTMENTS (SPECIFY)					
50	TOTAL (SUM OF LINES 1 THRU 49)		-2,108,823			

(1) Description - all chapter references in this columnpertain to CMS Pub. 15-I.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to worksheet A-7

Health Financial Systems MCRIF32 FOR WABASH GENERAL HOSPITAL IN LIEU OF FORM CMS-2552-96(9/1996)

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: 14-1327 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET A-8-2 I GROUP 1

	WKSHT A LINE NO. 1		COST CENTER/ PHYSICIAN IDENTIFIER 2	TOTAL REMUN-ERATION 3	PROFES-SIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	5 PERCENT OF UNADJUSTED RCE LIMIT 9
1	41	RADIOLOGY		5,058	5,058					
2	44	LAB		6,000	6,000					
3	49	RT		91,003	91,003					
4	59	ONCOLOGY		103,000	103,000					
5	61	ER		1,323,529	954,569	368,960				
6										
7										
8										
9										
10										
11										
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22										
23										
24										
25										
26										
27										
28										
29										
30										
101		TOTAL		1,528,590	1,159,630	368,960				

Health Financial Systems MCRIF32 FOR WABASH GENERAL HOSPITAL IN LIEU OF FORM CMS-2552-96(9/1996)

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: 14-1327 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET A-8-2 I GROUP 1

	WKSHT A LINE NO. 10		COST CENTER/ PHYSICIAN IDENTIFIER 11	COST OF MEMBERSHIPS & CONTINUING EDUCATION 12	PROVIDER COMPONENT SHARE OF COL 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COL 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUSTMENT 18
1	41	RADIOLOGY								5,058
2	44	LAB								6,000
3	49	RT								91,003
4	59	ONCOLOGY								103,000
5	61	ER								954,569
6										
7										
8										
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23										
24										
25										
26										
27										
28										
29										
30										
101		TOTAL								1,159,630

Health Financial Systems MCRIF32 FOR WABASH GENERAL HOSPITAL IN LIEU OF FORM CMS-2552-96(7/2009)

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 5/20/2010
I 14-1327 I FROM 1/ 1/2009 I NOT A CMS WORKSHEET
I I TO 12/31/2009 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION	
	GENERAL SERVICE COST			
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	3	SQUARE FEET	ENTERED
5	EMPLOYEE BENEFITS	S	GROSS SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM. COST	NOT ENTERED
8	OPERATION OF PLANT	3	SQUARE FEET	ENTERED
10	HOUSEKEEPING	9	POUNDS	ENTERED
11	DIETARY	10	MEALS SERVED	ENTERED
12	CAFETERIA	11	FTE'S	ENTERED
14	NURSING ADMINISTRATION	13	NURSE FTE'S	ENTERED
17	MEDICAL RECORDS & LIBRARY	16	TIME SPENT	ENTERED
18	SOCIAL SERVICE	17	DAYS	ENTERED
20	NONPHYSICIAN ANESTHETISTS	18	ASSIGNED TIME	ENTERED

	COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-MVBLE E	EMPLOYEE BENEFITS	SUBTOTAL	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT
		0	3	4	5	5a.00	6	8
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &	409,425	409,425					
004	NEW CAP REL COSTS-MVBLE E	1,085,500		1,085,500				
005	EMPLOYEE BENEFITS	3,298,233	1,097	2,908	3,302,238			
006	ADMINISTRATIVE & GENERAL	2,534,235	33,130	87,838	257,183	2,912,386	2,912,386	
008	OPERATION OF PLANT	726,019	19,654	52,109	52,227	850,009	122,174	972,183
010	HOUSEKEEPING	264,117	4,921	13,047	71,171	353,256	50,775	13,456
011	DIETARY	158,505	31,264	82,889	28,859	301,517	43,338	85,487
012	CAFETERIA	187,862			47,043	234,905	33,764	
014	NURSING ADMINISTRATION	141,374	2,362	6,261	43,555	193,552	27,820	6,457
017	MEDICAL RECORDS & LIBRARY	293,046	8,882	23,550	85,632	411,110	59,090	24,288
018	SOCIAL SERVICE	106,391	2,933	7,776	29,997	147,097	21,143	8,020
020	NONPHYSICIAN ANESTHETISTS	53,807			124,366	178,173	25,609	
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	1,418,127	76,902	203,892	366,710	2,065,631	296,899	210,279
026	INTENSIVE CARE UNIT	234,546	19,273	51,099	73,733	378,651	54,425	52,700
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM	755,130	53,158	140,936	174,382	1,123,606	161,499	145,353
040	ANESTHESIOLOGY							
041	RADIOLOGY-DIAGNOSTIC	1,259,456	37,236	98,724	185,572	1,580,988	227,240	101,818
044	LABORATORY	1,173,430	7,679	20,359	204,831	1,406,299	202,132	20,997
049	RESPIRATORY THERAPY	418,934	8,456	22,419	113,779	563,588	81,006	23,121
050	PHYSICAL THERAPY	490,928	16,089	42,657	149,574	699,248	100,505	43,993
055	MEDICAL SUPPLIES CHARGED	1,718,848	10,101	26,782	31,025	1,786,756	256,816	27,621
056	DRUGS CHARGED TO PATIENTS	1,468,891	3,855	10,220	93,554	1,576,520	226,598	10,540
059	ONCOLOGY	202,908	7,626	20,217	55,274	286,025	41,111	20,851
	OUTPAT SERVICE COST CNTRS							
060	CLINIC	24,586			4,754	29,340	4,217	
061	EMERGENCY	1,295,664	25,010	66,307	285,872	1,672,853	240,444	68,385
062	OBSERVATION BEDS (NON-DIS							
063	OTHER OUTPATIENT SERVICE							
063 50	RURAL HEALTH CLINIC	125,031	7,626	20,217	39,800	192,674	27,694	20,851
	OTHER REIMBURS COST CNTRS							
065	AMBULANCE SERVICES	475,154	27,181	72,064	136,076	710,475	102,119	74,322
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	20,320,147	404,435	1,072,271	2,654,969	19,654,659	2,406,418	958,539
	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP		1,950	5,170		7,120	1,023	5,333
098	PHYSICIANS' PRIVATE OFFIC	2,854,644	3,040	8,059	647,269	3,513,012	504,945	8,311
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	TOTAL	23,174,791	409,425	1,085,500	3,302,238	23,174,791	2,912,386	972,183

COST ALLOCATION - GENERAL SERVICE COSTS | PROVIDER NO: 14-1327 | PERIOD: FROM 1/ 1/2009 TO 12/31/2009 | PREPARED 5/20/2010 | WORKSHEET B PART I

	COST CENTER DESCRIPTION	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS
		10	11	12	14	17	18	20
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL							
008	OPERATION OF PLANT							
010	HOUSEKEEPING	417,487						
011	DIETARY	6,931	437,273					
012	CAFETERIA			268,669				
014	NURSING ADMINISTRATION			2,783	230,612			
017	MEDICAL RECORDS & LIBRARY			17,613		512,101		
018	SOCIAL SERVICE			3,544			179,804	
020	NONPHYSICIAN ANESTHETISTS			4,479				208,261
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	228,840	422,702	51,817	105,116	445,580	173,812	
026	INTENSIVE CARE UNIT		14,571	8,154	16,542	29,855	5,992	
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM	55,340		20,135	40,847			
040	ANESTHESIOLOGY							208,261
041	RADIOLOGY-DIAGNOSTIC	31,744		22,657				
044	LABORATORY	1,834		24,592				
049	RESPIRATORY THERAPY	1,975		15,047				
050	PHYSICAL THERAPY	25,307		14,938				
055	MEDICAL SUPPLIES CHARGED			2,109				
056	DRUGS CHARGED TO PATIENTS			9,480				
059	ONCOLOGY	952		7,828				
	OUTPAT SERVICE COST CNTRS							
060	CLINIC			739				
061	EMERGENCY	63,982		33,573	68,107	36,666		
062	OBSERVATION BEDS (NON-DIS							
063	OTHER OUTPATIENT SERVICE							
063 50	RURAL HEALTH CLINIC			3,088				
	OTHER REIMBURS COST CNTRS							
065	AMBULANCE SERVICES	582		26,093				
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	417,487	437,273	268,669	230,612	512,101	179,804	208,261
	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP							
098	PHYSICIANS' PRIVATE OFFIC							
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	TOTAL	417,487	437,273	268,669	230,612	512,101	179,804	208,261

	COST CENTER DESCRIPTION	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
		25	26	27
	GENERAL SERVICE COST CNTR			
003	NEW CAP REL COSTS-BLDG &			
004	NEW CAP REL COSTS-MVBLE E			
005	EMPLOYEE BENEFITS			
006	ADMINISTRATIVE & GENERAL			
008	OPERATION OF PLANT			
010	HOUSEKEEPING			
011	DIETARY			
012	CAFETERIA			
014	NURSING ADMINISTRATION			
017	MEDICAL RECORDS & LIBRARY			
018	SOCIAL SERVICE			
020	NONPHYSICIAN ANESTHETISTS			
	INPAT ROUTINE SRVC CNTRS			
025	ADULTS & PEDIATRICS	4,000,676		4,000,676
026	INTENSIVE CARE UNIT	560,890		560,890
	ANCILLARY SRVC COST CNTRS			
037	OPERATING ROOM	1,546,780		1,546,780
040	ANESTHESIOLOGY	208,261		208,261
041	RADIOLOGY-DIAGNOSTIC	1,964,447		1,964,447
044	LABORATORY	1,655,854		1,655,854
049	RESPIRATORY THERAPY	684,737		684,737
050	PHYSICAL THERAPY	883,991		883,991
055	MEDICAL SUPPLIES CHARGED	2,073,302		2,073,302
056	DRUGS CHARGED TO PATIENTS	1,823,138		1,823,138
059	ONCOLOGY	356,767		356,767
	OUTPAT SERVICE COST CNTRS			
060	CLINIC	34,296		34,296
061	EMERGENCY	2,184,010		2,184,010
062	OBSERVATION BEDS (NON-DIS			
063	OTHER OUTPATIENT SERVICE			
063 50	RURAL HEALTH CLINIC	244,307		244,307
	OTHER REIMBURS COST CNTRS			
065	AMBULANCE SERVICES	913,591		913,591
	SPEC PURPOSE COST CENTERS			
095	SUBTOTALS	19,135,047		19,135,047
	NONREIMBURS COST CENTERS			
096	GIFT, FLOWER, COFFEE SHOP	13,476		13,476
098	PHYSICIANS' PRIVATE OFFIC	4,026,268		4,026,268
101	CROSS FOOT ADJUSTMENT			
102	NEGATIVE COST CENTER			
103	TOTAL	23,174,791		23,174,791

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: 14-1327 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET B I PART III

	COST CENTER DESCRIPTION	DIR ASSGNED NEW CAPITAL REL COSTS 0	NEW CAP REL COSTS-BLDG & 3	NEW CAP REL COSTS-MVBLE E 4	SUBTOTAL 4a	EMPLOYEE BENEFITS 5	ADMINISTRATIVE & GENERAL 6	OPERATION OF PLANT 8
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS		1,097	2,908	4,005	4,005		
006	ADMINISTRATIVE & GENERAL		33,130	87,838	120,968	312	121,280	
008	OPERATION OF PLANT		19,654	52,109	71,763	63	5,087	76,913
010	HOUSEKEEPING		4,921	13,047	17,968	86	2,114	1,065
011	DIETARY		31,264	82,889	114,153	35	1,805	6,763
012	CAFETERIA					57	1,406	
014	NURSING ADMINISTRATION		2,362	6,261	8,623	53	1,158	511
017	MEDICAL RECORDS & LIBRARY		8,882	23,550	32,432	104	2,460	1,922
018	SOCIAL SERVICE		2,933	7,776	10,709	36	880	634
020	NONPHYSICIAN ANESTHETISTS					151	1,066	
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS		76,902	203,892	280,794	445	12,363	16,636
026	INTENSIVE CARE UNIT		19,273	51,099	70,372	89	2,266	4,169
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM		53,158	140,936	194,094	211	6,725	11,499
040	ANESTHESIOLOGY							
041	RADIOLOGY-DIAGNOSTIC		37,236	98,724	135,960	225	9,462	8,055
044	LABORATORY		7,679	20,359	28,038	248	8,417	1,661
049	RESPIRATORY THERAPY		8,456	22,419	30,875	138	3,373	1,829
050	PHYSICAL THERAPY		16,089	42,657	58,746	181	4,185	3,480
055	MEDICAL SUPPLIES CHARGED		10,101	26,782	36,883	38	10,694	2,185
056	DRUGS CHARGED TO PATIENTS		3,855	10,220	14,075	113	9,435	834
059	ONCOLOGY		7,626	20,217	27,843	67	1,712	1,650
	OUTPAT SERVICE COST CNTRS							
060	CLINIC					6	176	
061	EMERGENCY		25,010	66,307	91,317	347	10,012	5,410
062	OBSERVATION BEDS (NON-DIS							
063	OTHER OUTPATIENT SERVICE							
063 50	RURAL HEALTH CLINIC		7,626	20,217	27,843	48	1,153	1,650
	OTHER REIMBURS COST CNTRS							
065	AMBULANCE SERVICES		27,181	72,064	99,245	165	4,252	5,880
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS		404,435	1,072,271	1,476,706	3,218	100,201	75,833
	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP		1,950	5,170	7,120		43	422
8	PHYSICIANS' PRIVATE OFFIC		3,040	8,059	11,099	787	21,036	658
1	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL		409,425	1,085,500	1,494,925	4,005	121,280	76,913

	COST CENTER DESCRIPTION	HOUSEKEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMINISTRATION 14	MEDICAL RECORDS & LIBRARY 17	SOCIAL SERVICE 18	NONPHYSICIAN ANESTHETISTS 20
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL							
008	OPERATION OF PLANT							
010	HOUSEKEEPING	21,233						
011	DIETARY	352	123,108					
012	CAFETERIA			1,463				
014	NURSING ADMINISTRATION			15	10,360			
017	MEDICAL RECORDS & LIBRARY			96		37,014		
018	SOCIAL SERVICE			19			12,278	
020	NONPHYSICIAN ANESTHETISTS			24				1,241
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	11,640	119,006	283	4,722	32,206	11,869	
026	INTENSIVE CARE UNIT		4,102	44	743	2,158	409	
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM	2,815		110	1,835			
040	ANESTHESIOLOGY							
041	RADIOLOGY-DIAGNOSTIC	1,614		123				
044	LABORATORY	93		134				
049	RESPIRATORY THERAPY	100		82				
050	PHYSICAL THERAPY	1,287		81				
055	MEDICAL SUPPLIES CHARGED			11				
056	DRUGS CHARGED TO PATIENTS			52				
059	ONCOLOGY	48		43				
	OUTPAT SERVICE COST CNTRS							
060	CLINIC			4				
061	EMERGENCY	3,254		183	3,060	2,650		
062	OBSERVATION BEDS (NON-DIS							
063	OTHER OUTPATIENT SERVICE							
063 50	RURAL HEALTH CLINIC			17				
	OTHER REIMBURS COST CNTRS							
065	AMBULANCE SERVICES	30		142				
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	21,233	123,108	1,463	10,360	37,014	12,278	
	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP							
[illegible]8	PHYSICIANS' PRIVATE OFFIC							1,241
[illegible]1	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	21,233	123,108	1,463	10,360	37,014	12,278	1,241

	COST CENTER DESCRIPTION	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
		25	26	27
	GENERAL SERVICE COST CNTR			
003	NEW CAP REL COSTS-BLDG &			
004	NEW CAP REL COSTS-MVBLE E			
005	EMPLOYEE BENEFITS			
006	ADMINISTRATIVE & GENERAL			
008	OPERATION OF PLANT			
010	HOUSEKEEPING			
011	DIETARY			
012	CAFETERIA			
014	NURSING ADMINISTRATION			
017	MEDICAL RECORDS & LIBRARY			
018	SOCIAL SERVICE			
020	NONPHYSICIAN ANESTHETISTS			
	INPAT ROUTINE SRVC CNTRS			
025	ADULTS & PEDIATRICS	489,964		489,964
026	INTENSIVE CARE UNIT	84,352		84,352
	ANCILLARY SRVC COST CNTRS			
037	OPERATING ROOM	217,289		217,289
040	ANESTHESIOLOGY			
041	RADIOLOGY-DIAGNOSTIC	155,439		155,439
044	LABORATORY	38,591		38,591
049	RESPIRATORY THERAPY	36,397		36,397
050	PHYSICAL THERAPY	67,960		67,960
055	MEDICAL SUPPLIES CHARGED	49,811		49,811
056	DRUGS CHARGED TO PATIENTS	24,509		24,509
059	ONCOLOGY	31,363		31,363
	OUTPAT SERVICE COST CNTRS			
060	CLINIC	186		186
061	EMERGENCY	116,233		116,233
062	OBSERVATION BEDS (NON-DIS			
063	OTHER OUTPATIENT SERVICE			
063 50	RURAL HEALTH CLINIC	30,711		30,711
	OTHER REIMBURS COST CNTRS			
065	AMBULANCE SERVICES	109,714		109,714
	SPEC PURPOSE COST CENTERS			
095	SUBTOTALS	1,452,519		1,452,519
	NONREIMBURS COST CENTERS			
096	GIFT, FLOWER, COFFEE SHOP	7,585		7,585
098	PHYSICIANS' PRIVATE OFFIC	33,580		33,580
101	CROSS FOOT ADJUSTMENTS	1,241		1,241
102	NEGATIVE COST CENTER			
103	TOTAL	1,494,925		1,494,925

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: 14-1327 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET B-1

	COST CENTER DESCRIPTION	NEW CAP REL COSTS-BLDG & (SQUARE FEET)	NEW CAP REL COSTS-MVBLE EQ (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)
		3	4	5	6a.00	6	8
	GENERAL SERVICE COST						
003	NEW CAP REL COSTS-BLD	53,745					
004	NEW CAP REL COSTS-MVB		53,745				
005	EMPLOYEE BENEFITS	144	144	10,112,957			
006	ADMINISTRATIVE & GENE	4,349	4,349	787,611	-2,912,386	20,262,405	
008	OPERATION OF PLANT	2,580	2,580	159,943		850,009	46,672
010	HOUSEKEEPING	646	646	217,959		353,256	646
011	DIETARY	4,104	4,104	88,380		301,517	4,104
012	CAFETERIA			144,068		234,905	
014	NURSING ADMINISTRATIO	310	310	133,385		193,552	310
017	MEDICAL RECORDS & LIB	1,166	1,166	262,245		411,110	1,166
018	SOCIAL SERVICE	385	385	91,866		147,097	385
020	NONPHYSICIAN ANESTHET			380,866		178,173	
	INPAT ROUTINE SRVC CN						
025	ADULTS & PEDIATRICS	10,095	10,095	1,123,035		2,065,631	10,095
026	INTENSIVE CARE UNIT	2,530	2,530	225,805		378,651	2,530
	ANCILLARY SRVC COST C						
037	OPERATING ROOM	6,978	6,978	534,038		1,123,606	6,978
040	ANESTHESIOLOGY						
041	RADIOLOGY-DIAGNOSTIC	4,888	4,888	568,306		1,580,988	4,888
044	LABORATORY	1,008	1,008	627,288		1,406,299	1,008
049	RESPIRATORY THERAPY	1,110	1,110	348,445		563,588	1,110
050	PHYSICAL THERAPY	2,112	2,112	458,065		699,248	2,112
055	MEDICAL SUPPLIES CHAR	1,326	1,326	95,012		1,786,756	1,326
056	DRUGS CHARGED TO PATI	506	506	286,505		1,576,520	506
059	ONCOLOGY	1,001	1,001	169,273		286,025	1,001
	OUTPAT SERVICE COST C						
060	CLINIC			14,560		29,340	
061	EMERGENCY	3,283	3,283	875,470		1,672,853	3,283
062	OBSERVATION BEDS (NON						
063	OTHER OUTPATIENT SERV						
063 50	RURAL HEALTH CLINIC	1,001	1,001	121,887		192,674	1,001
	OTHER REIMBURS COST C						
065	AMBULANCE SERVICES	3,568	3,568	416,727		710,475	3,568
	SPEC PURPOSE COST CEN						
[illegible]5	SUBTOTALS	53,090	53,090	8,130,739	-2,912,386	16,742,273	46,017
	NONREIMBURS COST CENT						
096	GIFT, FLOWER, COFFEE	256	256			7,120	256
098	PHYSICIANS' PRIVATE O	399	399	1,982,218		3,513,012	399
101	CROSS FOOT ADJUSTMENT						
102	NEGATIVE COST CENTER						
103	COST TO BE ALLOCATED (WRKSHT B, PART I)	409,425	1,085,500	3,302,238		2,912,386	972,183
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	7.617918	20.197228	.326535		.143733	20.830112
105	COST TO BE ALLOCATED (WRKSHT B, PART II)						
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)						
107	COST TO BE ALLOCATED (WRKSHT B, PART III			4,005		121,280	76,913
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)			.000396		.005985	1.647947

	COST CENTER DESCRIPTION	HOUSEKEEPING (POUNDS)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (NURSE FTE'S)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)
		10	11	12	14	17	18	20
	GENERAL SERVICE COST							
003	NEW CAP REL COSTS-BLD							
004	NEW CAP REL COSTS-MVB							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENE							
008	OPERATION OF PLANT							
010	HOUSEKEEPING	23,673						
011	DIETARY	393	9,183					
012	CAFETERIA			12,356				
014	NURSING ADMINISTRATIO			128	5,228			
017	MEDICAL RECORDS & LIB			810		10,000		
018	SOCIAL SERVICE			163			3,061	
020	NONPHYSICIAN ANESTHET			206				100
	INPAT ROUTINE SRVC CN							
025	ADULTS & PEDIATRICS	12,976	8,877	2,383	2,383	8,701	2,959	
026	INTENSIVE CARE UNIT		306	375	375	583	102	
	ANCILLARY SRVC COST C							
037	OPERATING ROOM	3,138		926	926			
040	ANESTHESIOLOGY							100
041	RADIOLOGY-DIAGNOSTIC	1,800		1,042				
044	LABORATORY	104		1,131				
049	RESPIRATORY THERAPY	112		692				
050	PHYSICAL THERAPY	1,435		687				
055	MEDICAL SUPPLIES CHAR			97				
056	DRUGS CHARGED TO PATI			436				
059	ONCOLOGY	54		360				
	OUTPAT SERVICE COST C							
060	CLINIC			34				
061	EMERGENCY	3,628		1,544	1,544	716		
062	OBSERVATION BEDS (NON							
063	OTHER OUTPATIENT SERV							
063 50	RURAL HEALTH CLINIC			142				
	OTHER REIMBURS COST C							
065	AMBULANCE SERVICES	33		1,200				
	SPEC PURPOSE COST CEN							
5	SUBTOTALS	23,673	9,183	12,356	5,228	10,000	3,061	100
	NONREIMBURS COST CENT							
096	GIFT, FLOWER, COFFEE							
098	PHYSICIANS' PRIVATE O							
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED (WRKSHT B, PART I)	417,487	437,273	268,669	230,612	512,101	179,804	208,261
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	17.635576	47.617663	21.744011	44.110941	51.210100	58.740281	2,082.610000
105	COST TO BE ALLOCATED (WRKSHT B, PART II)							
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)							
107	COST TO BE ALLOCATED (WRKSHT B, PART III	21,233	123,108	1,463	10,360	37,014	12,278	1,241
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)	.896929	13.406076	.118404	1.981637	3.701400	4.011107	12.410000

Health Financial Systems MCRIF32 FOR WABASH GENERAL HOSPITAL IN LIEU OF FORM CMS-2552-96(07/2009)

COMPUTATION OF RATIO OF COSTS TO CHARGES | PROVIDER NO: 14-1327 | PERIOD: FROM 1/ 1/2009 TO 12/31/2009 | PREPARED 5/20/2010 | WORKSHEET C PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	4,000,676		4,000,676		
26	INTENSIVE CARE UNIT	560,890		560,890		
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,546,780		1,546,780		
40	ANESTHESIOLOGY	208,261		208,261		
41	RADIOLOGY-DIAGNOSTIC	1,964,447		1,964,447		
44	LABORATORY	1,655,854		1,655,854		
49	RESPIRATORY THERAPY	684,737		684,737		
50	PHYSICAL THERAPY	883,991		883,991		
55	MEDICAL SUPPLIES CHARGED	2,073,302		2,073,302		
56	DRUGS CHARGED TO PATIENTS	1,823,138		1,823,138		
59	ONCOLOGY	356,767		356,767		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	34,296		34,296		
61	EMERGENCY	2,184,010		2,184,010		
62	OBSERVATION BEDS (NON-DIS	990,195		990,195		
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC	244,307		244,307		
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	913,591		913,591		
101	SUBTOTAL	20,125,242		20,125,242		
102	LESS OBSERVATION BEDS	990,195		990,195		
103	TOTAL	19,135,047		19,135,047		

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: 14-1327 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET C I PART I

WKST A LINE NO.		COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
		INPAT ROUTINE SRVC CNTRS						
25		ADULTS & PEDIATRICS	2,674,639		2,674,639			
26		INTENSIVE CARE UNIT	100,938		100,938			
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	1,322,689	4,163,826	5,486,515	.281924	.281924	
40		ANESTHESIOLOGY	428,789	1,013,533	1,442,322	.144393	.144393	
41		RADIOLOGY-DIAGNOSTIC	602,141	9,756,599	10,358,740	.189642	.189642	
44		LABORATORY	854,387	7,872,045	8,726,432	.189752	.189752	
49		RESPIRATORY THERAPY	386,415	1,214,170	1,600,585	.427804	.427804	
50		PHYSICAL THERAPY	259,541	1,217,677	1,477,218	.598416	.598416	
55		MEDICAL SUPPLIES CHARGED	2,388,333	1,255,236	3,643,569	.569031	.569031	
56		DRUGS CHARGED TO PATIENTS	1,513,476	3,016,691	4,530,167	.402444	.402444	
59		ONCOLOGY		438,550	438,550	.813515	.813515	
		OUTPAT SERVICE COST CNTRS						
60		CLINIC		72,486	72,486	.473140	.473140	
61		EMERGENCY	55,388	3,330,585	3,385,973	.645017	.645017	
62		OBSERVATION BEDS (NON-DIS		708,755	708,755	1.397091	1.397091	
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC		259,125	259,125	.942815	.942815	
		OTHER REIMBURS COST CNTRS						
65		AMBULANCE SERVICES		1,169,316	1,169,316	.781304	.781304	
101		SUBTOTAL	10,586,736	35,488,594	46,075,330			
102		LESS OBSERVATION BEDS						
103		TOTAL	10,586,736	35,488,594	46,075,330			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

PROVIDER NO: 14-1327
PERIOD: FROM 1/ 1/2009 TO 12/31/2009
PREPARED 5/20/2010
WORKSHEET C
PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	4,000,676		4,000,676		
26	INTENSIVE CARE UNIT	560,890		560,890		
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,546,780		1,546,780		
40	ANESTHESIOLOGY	208,261		208,261		
41	RADIOLOGY-DIAGNOSTIC	1,964,447		1,964,447		
44	LABORATORY	1,655,854		1,655,854		
49	RESPIRATORY THERAPY	684,737		684,737		
50	PHYSICAL THERAPY	883,991		883,991		
55	MEDICAL SUPPLIES CHARGED	2,073,302		2,073,302		
56	DRUGS CHARGED TO PATIENTS	1,823,138		1,823,138		
59	ONCOLOGY	356,767		356,767		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	34,296		34,296		
61	EMERGENCY	2,184,010		2,184,010		
62	OBSERVATION BEDS (NON-DIS	990,195		990,195		
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC	244,307		244,307		
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	913,591		913,591		
101	SUBTOTAL	20,125,242		20,125,242		
102	LESS OBSERVATION BEDS	990,195		990,195		
103	TOTAL	19,135,047		19,135,047		

Health Financial Systems MCRIF32 FOR WABASH GENERAL HOSPITAL **NOT A CMS WORKSHEET ** (07/2009)

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: 14-1327 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET C PART I

WKST A LINE NO.		COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
		INPAT ROUTINE SRVC CNTRS						
25		ADULTS & PEDIATRICS	2,674,639		2,674,639			
26		INTENSIVE CARE UNIT	100,938		100,938			
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	1,322,689	4,163,826	5,486,515	.281924	.281924	
40		ANESTHESIOLOGY	428,789	1,013,533	1,442,322	.144393	.144393	
41		RADIOLOGY-DIAGNOSTIC	602,141	9,756,599	10,358,740	.189642	.189642	
44		LABORATORY	854,387	7,872,045	8,726,432	.189752	.189752	
49		RESPIRATORY THERAPY	386,415	1,214,170	1,600,585	.427804	.427804	
50		PHYSICAL THERAPY	259,541	1,217,677	1,477,218	.598416	.598416	
55		MEDICAL SUPPLIES CHARGED	2,388,333	1,255,236	3,643,569	.569031	.569031	
56		DRUGS CHARGED TO PATIENTS	1,513,476	3,016,691	4,530,167	.402444	.402444	
59		ONCOLOGY		438,550	438,550	.813515	.813515	
		OUTPAT SERVICE COST CNTRS						
60		CLINIC		72,486	72,486	.473140	.473140	
61		EMERGENCY	55,388	3,330,585	3,385,973	.645017	.645017	
62		OBSERVATION BEDS (NON-DIS		708,755	708,755	1.397091	1.397091	
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC		259,125	259,125	.942815	.942815	
		OTHER REIMBURS COST CNTRS						
65		AMBULANCE SERVICES		1,169,316	1,169,316	.781304	.781304	
101		SUBTOTAL	10,586,736	35,488,594	46,075,330			
102		LESS OBSERVATION BEDS						
103		TOTAL	10,586,736	35,488,594	46,075,330			

Health Financial Systems MCRIF32 FOR WABASH GENERAL HOSPITAL IN LIEU OF FORM CMS-2552-96(09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS

I PROVIDER NO: 14-1327 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET C I PART II

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III,COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	1,546,780	217,289	1,329,491			1,546,780
40	ANESTHESIOLOGY	208,261		208,261			208,261
41	RADIOLOGY-DIAGNOSTIC	1,964,447	155,439	1,809,008			1,964,447
44	LABORATORY	1,655,854	38,591	1,617,263			1,655,854
49	RESPIRATORY THERAPY	684,737	36,397	648,340			684,737
50	PHYSICAL THERAPY	883,991	67,960	816,031			883,991
55	MEDICAL SUPPLIES CHARGED	2,073,302	49,811	2,023,491			2,073,302
56	DRUGS CHARGED TO PATIENTS	1,823,138	24,509	1,798,629			1,823,138
59	ONCOLOGY	356,767	31,363	325,404			356,767
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	34,296	186	34,110			34,296
61	EMERGENCY	2,184,010	116,233	2,067,777			2,184,010
62	OBSERVATION BEDS (NON-DIS	990,195		990,195			990,195
63	OTHER OUTPATIENT SERVICE						
63 50	RURAL HEALTH CLINIC	244,307	30,711	213,596			244,307
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES	913,591	109,714	803,877			913,591
101	SUBTOTAL	15,563,676	878,203	14,685,473			15,563,676
102	LESS OBSERVATION BEDS	990,195		990,195			990,195
103	TOTAL	14,573,481	878,203	13,695,278			14,573,481

Health Financial Systems MCRIF32 FOR WABASH GENERAL HOSPITAL IN LIEU OF FORM CMS-2552-96(09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS | PROVIDER NO: 14-1327 | PERIOD: FROM 1/ 1/2009 TO 12/31/2009 | PREPARED 5/20/2010 | WORKSHEET C PART II

WKST A LINE NO.		COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
			7	8	9
		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	5,486,515	.281924	.281924
40		ANESTHESIOLOGY	1,442,322	.144393	.144393
41		RADIOLOGY-DIAGNOSTIC	10,358,740	.189642	.189642
44		LABORATORY	8,726,432	.189752	.189752
49		RESPIRATORY THERAPY	1,600,585	.427804	.427804
50		PHYSICAL THERAPY	1,477,218	.598416	.598416
55		MEDICAL SUPPLIES CHARGED	3,643,569	.569031	.569031
56		DRUGS CHARGED TO PATIENTS	4,530,167	.402444	.402444
59		ONCOLOGY	438,550	.813515	.813515
		OUTPAT SERVICE COST CNTRS			
60		CLINIC	72,486	.473140	.473140
61		EMERGENCY	3,385,973	.645017	.645017
62		OBSERVATION BEDS (NON-DIS	708,755	1.397091	1.397091
63		OTHER OUTPATIENT SERVICE			
63	50	RURAL HEALTH CLINIC	259,125	.942815	.942815
		OTHER REIMBURS COST CNTRS			
65		AMBULANCE SERVICES	1,169,316	.781304	.781304
101		SUBTOTAL	43,299,753		
102		LESS OBSERVATION BEDS	708,755		
103		TOTAL	42,590,998		

Health Financial Systems MCRIF32 FOR WABASH GENERAL HOSPITAL **NOT A CMS WORKSHEET ** (09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS SPECIAL TITLE XIX WORKSHEET

PROVIDER NO: 14-1327 PERIOD: FROM 1/ 1/2009 TO 12/31/2009

PREPARED 5/20/2010 WORKSHEET C PART II

WKST A LINE NO.		COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	1,546,780	217,289	1,329,491			1,546,780
40		ANESTHESIOLOGY	208,261		208,261			208,261
41		RADIOLOGY-DIAGNOSTIC	1,964,447	155,439	1,809,008			1,964,447
44		LABORATORY	1,655,854	38,591	1,617,263			1,655,854
49		RESPIRATORY THERAPY	684,737	36,397	648,340			684,737
50		PHYSICAL THERAPY	883,991	67,960	816,031			883,991
55		MEDICAL SUPPLIES CHARGED	2,073,302	49,811	2,023,491			2,073,302
56		DRUGS CHARGED TO PATIENTS	1,823,138	24,509	1,798,629			1,823,138
59		ONCOLOGY	356,767	31,363	325,404			356,767
		OUTPAT SERVICE COST CNTRS						
60		CLINIC	34,296	186	34,110			34,296
61		EMERGENCY	2,184,010	116,233	2,067,777			2,184,010
62		OBSERVATION BEDS (NON-DIS	990,195		990,195			990,195
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC	244,307	30,711	213,596			244,307
		OTHER REIMBURS COST CNTRS						
65		AMBULANCE SERVICES	913,591	109,714	803,877			913,591
101		SUBTOTAL	15,563,676	878,203	14,685,473			15,563,676
102		LESS OBSERVATION BEDS	990,195		990,195			990,195
103		TOTAL	14,573,481	878,203	13,695,278			14,573,481

Health Financial Systems MCRIF32 FOR WABASH GENERAL HOSPITAL **NOT A CMS WORKSHEET ** (09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS SPECIAL TITLE XIX WORKSHEET

PROVIDER NO: 14-1327 PERIOD: FROM 1/ 1/2009 TO 12/31/2009 PREPARED 5/20/2010 WORKSHEET C PART II

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	5,486,515	.281924	.281924
40	ANESTHESIOLOGY	1,442,322	.144393	.144393
41	RADIOLOGY-DIAGNOSTIC	10,358,740	.189642	.189642
44	LABORATORY	8,726,432	.189752	.189752
49	RESPIRATORY THERAPY	1,600,585	.427804	.427804
50	PHYSICAL THERAPY	1,477,218	.598416	.598416
55	MEDICAL SUPPLIES CHARGED	3,643,569	.569031	.569031
56	DRUGS CHARGED TO PATIENTS	4,530,167	.402444	.402444
59	ONCOLOGY	438,550	.813515	.813515
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	72,486	.473140	.473140
61	EMERGENCY	3,385,973	.645017	.645017
62	OBSERVATION BEDS (NON-DIS	708,755	1.397091	1.397091
63	OTHER OUTPATIENT SERVICE			
63 50	RURAL HEALTH CLINIC	259,125	.942815	.942815
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES	1,169,316	.781304	.781304
101	SUBTOTAL	43,299,753		
102	LESS OBSERVATION BEDS	708,755		
103	TOTAL	42,590,998		

Health Financial Systems MCRIF32 FOR WABASH GENERAL HOSPITAL IN LIEU OF FORM CMS-2552-96(09/1997)

COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY COSTS

I PROVIDER NO: 14-1327 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET C I PART III

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	TOTAL ANCILLARY CHARGES 2	TOTAL INP ANCILLARY CHARGES 3	CHARGE TO CHARGE RATIO 4	TOTAL INPATIENT COST 5
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,043,584	3,295,036			
40	ANESTHESIOLOGY	69,492	586,937			
41	RADIOLOGY-DIAGNOSTIC	1,515,411	8,195,790			
44	LABORATORY	909,161	6,715,012			
49	RESPIRATORY THERAPY	480,989	1,748,373			
50	PHYSICAL THERAPY	581,460	1,013,692			
55	MEDICAL SUPPLIES CHARGED	2,137,821	3,468,197			
56	DRUGS CHARGED TO PATIENTS	1,098,671	2,822,173			
59	ONCOLOGY					
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	80,714	16,457			
61	EMERGENCY	1,604,086	2,149,287			
62	OBSERVATION BEDS (NON-DIS	801,632	586,625			
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC					
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	714,321	1,042,533			
101	TOTAL	11,037,342	31,640,112			

Health Financial Systems MCRIF32 FOR WABASH GENERAL HOSPITAL IN LIEU OF FORM CMS-2552-96(09/1996)

COMPUTATION OF OUTPATIENT COST PER VISIT - RURAL PRIMARY CARE HOSPITAL

PROVIDER NO: 14-1327 | PERIOD: FROM 1/ 1/2009 TO 12/31/2009 | PREPARED 5/20/2010 | WORKSHEET C PART V

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	PROVIDER-BASED PHYSICIAN ADJUSTMENT 2	TOTAL COSTS 3	TOTAL ANCILLARY CHARGES 4	TOTAL OUTPATIENT CHARGES 5	RATIO OF OUT-PATIENT CHRGS TO TTL CHARGES 6	TOTAL OUT-PATIENT COSTS 7
	ANCILLARY SRVC COST CNTRS							
37	OPERATING ROOM	1,043,584		1,043,584	3,295,036			
40	ANESTHESIOLOGY	69,492		69,492	586,937			
41	RADIOLOGY-DIAGNOSTIC	1,515,411	5,086	1,520,497	8,195,790			
44	LABORATORY	909,161	5,000	914,161	6,715,012			
49	RESPIRATORY THERAPY	480,989	58,854	539,843	1,748,373			
50	PHYSICAL THERAPY	581,460		581,460	1,013,692			
55	MEDICAL SUPPLIES CHARGED	2,137,821		2,137,821	3,468,197			
56	DRUGS CHARGED TO PATIENTS	1,098,671		1,098,671	2,822,173			
59	ONCOLOGY							
	OUTPAT SERVICE COST CNTRS							
60	CLINIC	80,714		80,714	16,457			
61	EMERGENCY	1,604,086	753,538	2,357,624	2,149,287			
62	OBSERVATION BEDS (NON-DIS	801,632		801,632	586,625			
63	OTHER OUTPATIENT SERVICE							
63 50	RURAL HEALTH CLINIC							
	OTHER REIMBURS COST CNTRS							
65	AMBULANCE SERVICES	714,321		714,321	1,042,533			
101	TOTAL	11,037,342	822,478	11,859,820	31,640,112			
102	TOTAL OUTPATIENT VISITS							
103	AGGREGATE COST PER VISIT							
104	TITLE V OUTPATIENT VISITS							
105	TITLE XVIII OUTPAT VISITS							
106	TITLE XIX OUTPAT VISITS							
107	TITLE V OUTPAT COSTS							
108	TITLE XVIII OUTPAT COSTS							
109	TITLE XIX OUTPAT COSTS							

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1327	FROM 1/ 1/2009	WORKSHEET D
COMPONENT NO:	TO 12/31/2009	PART V
14-1327		

TITLE XVIII, PART B HOSPITAL

	Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy
		1	1.01	1.02	2	3
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	.281924		.281924		
40	ANESTHESIOLOGY	.144393		.144393		
41	RADIOLOGY-DIAGNOSTIC	.189642		.189642		
44	LABORATORY	.189752		.189752		
49	RESPIRATORY THERAPY	.427804		.427804		
50	PHYSICAL THERAPY	.598416		.598416		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.569031		.569031		
56	DRUGS CHARGED TO PATIENTS	.402444		.402444		
59	ONCOLOGY	.813515		.813515		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	.473140		.473140		
61	EMERGENCY	.645017		.645017		
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.397091		1.397091		
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC					
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	.781304		.781304		
101	SUBTOTAL					
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES					

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS | PROVIDER NO: 14-1327 | PERIOD: FROM 1/ 1/2009 TO 12/31/2009 | PREPARED 5/20/2010 | WORKSHEET D PART V

COMPONENT NO: 14-1327

TITLE XVIII, PART B HOSPITAL

	Cost Center Description	Other Outpatient Diagnostic 4	All Other (1) 5	Outpatient Ambulatory Surgical Ctr 6	Outpatient Radiology 7	Other Outpatient Diagnostic 8
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM		1,336,183			
40	ANESTHESIOLOGY		324,181			
41	RADIOLOGY-DIAGNOSTIC		3,797,577			
44	LABORATORY		3,906,401			
49	RESPIRATORY THERAPY		484,969			
50	PHYSICAL THERAPY		452,823			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		414,337			
56	DRUGS CHARGED TO PATIENTS		1,327,229			
59	ONCOLOGY		98,840			
	OUTPAT SERVICE COST CNTRS					
60	CLINIC					
61	EMERGENCY		959,375			
62	OBSERVATION BEDS (NON-DISTINCT PART)		700,835			
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC					
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES					
101	SUBTOTAL		13,802,750			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES		13,802,750			

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

PROVIDER NO:	PERIOD:	PREPARED
14-1327	FROM 1/ 1/2009	WORKSHEET D
COMPONENT NO:	TO 12/31/2009	PART V
14-1327		

TITLE XVIII, PART B HOSPITAL

	Cost Center Description	All Other 9	Hospital I/P Part B Charges 10	Hospital I/P Part B Costs 11
(A)	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	376,702		
40	ANESTHESIOLOGY	46,809		
41	RADIOLOGY-DIAGNOSTIC	720,180		
44	LABORATORY	741,247		
49	RESPIRATORY THERAPY	207,472		
50	PHYSICAL THERAPY	270,977		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	235,771		
56	DRUGS CHARGED TO PATIENTS	534,135		
59	ONCOLOGY	80,408		
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	618,813		
62	OBSERVATION BEDS (NON-DISTINCT PART)	979,130		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	SUBTOTAL	4,811,644		
102	CRNA CHARGES			
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES			
104	NET CHARGES	4,811,644		

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: 14-1327 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010
I COMPONENT NO: 14-1327 I WORKSHEET D PART V

TITLE XIX - O/P HOSPITAL

		Cost/Charge Ratio (C, Pt I, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy	Other Outpatient Diagnostic	All Other (1)
	Cost Center Description	1	2	3	4	5
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	.281924				507,021
40	ANESTHESIOLOGY	.144393				122,031
41	RADIOLOGY-DIAGNOSTIC	.189642				1,647,767
44	LABORATORY	.189752				1,017,398
49	RESPIRATORY THERAPY	.427804				174,748
50	PHYSICAL THERAPY	.598416				130,505
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.569031				166,742
56	DRUGS CHARGED TO PATIENTS	.402444				475,160
59	ONCOLOGY	.813515				89,377
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	.473140				15,952
61	EMERGENCY	.645017				928,321
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.397091				
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC	.942815				100,850
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	.781304				
101	SUBTOTAL					5,375,872
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES					5,375,872

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1327	FROM 1/ 1/2009	WORKSHEET D
COMPONENT NO:	TO 12/31/2009	PART V
14-1327		

TITLE XIX - O/P HOSPITAL

	Cost Center Description	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy
		5.01	5.02	5.03	6	7
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM					
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC					
44	LABORATORY					
49	RESPIRATORY THERAPY					
50	PHYSICAL THERAPY					
55	MEDICAL SUPPLIES CHARGED TO PATIENTS					
56	DRUGS CHARGED TO PATIENTS					
59	ONCOLOGY					
	OUTPAT SERVICE COST CNTRS					
60	CLINIC					
61	EMERGENCY					
62	OBSERVATION BEDS (NON-DISTINCT PART)					
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC					
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES					
101	SUBTOTAL					
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES					

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS | PROVIDER NO: 14-1327 | PERIOD: FROM 1/ 1/2009 TO 12/31/2009 | PREPARED 5/20/2010 | WORKSHEET D PART V

COMPONENT NO: 14-1327

TITLE XIX - O/P HOSPITAL

		Other Outpatient Diagnostic	All Other	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE
	Cost Center Description	8	9	9.01	9.02	9.03
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM		142,941			
40	ANESTHESIOLOGY		17,620			
41	RADIOLOGY-DIAGNOSTIC		312,486			
44	LABORATORY		193,053			
49	RESPIRATORY THERAPY		74,758			
50	PHYSICAL THERAPY		78,096			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		94,881			
56	DRUGS CHARGED TO PATIENTS		191,225			
59	ONCOLOGY		72,710			
	OUTPAT SERVICE COST CNTRS					
60	CLINIC		7,548			
61	EMERGENCY		598,783			
62	OBSERVATION BEDS (NON-DISTINCT PART)					
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC		95,083			
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES					
101	SUBTOTAL		1,879,184			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES		1,879,184			

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1327	FROM 1/ 1/2009	WORKSHEET D-1
COMPONENT NO:	TO 12/31/2009	PART I
14-1327		

TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,864
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,465
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,465
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	362
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	37
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,933
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	362
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	90.06
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	90.06
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	4,000,676
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	3,332
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	381,445
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,619,231
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,383,394
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,383,394
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.069704
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	976.45
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	3,619,231

TITLE XVIII PART A HOSPITAL OTHER

ART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	1,044.51
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	2,019,038
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	2,019,038

		TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY)					
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43	INTENSIVE CARE UNIT	560,890	102	5,498.92	53	291,443
44	CORONARY CARE UNIT					
45	BURN INTENSIVE CARE UNIT					
46	SURGICAL INTENSIVE CARE UNIT					
47	OTHER SPECIAL CARE					

1

48	PROGRAM INPATIENT ANCILLARY SERVICE COST	1,783,161
49	TOTAL PROGRAM INPATIENT COSTS	4,093,642

PASS THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES
52	TOTAL PROGRAM EXCLUDABLE COST
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES
55	TARGET AMOUNT PER DISCHARGE
56	TARGET AMOUNT
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
58	BONUS PAYMENT
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.
58.04	RELIEF PAYMENT
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1
59.03	PROGRAM DISCHARGES AFTER JULY 1
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	378,113
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	378,113
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS	

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1327	FROM 1/ 1/2009	WORKSHEET D-1
COMPONENT NO:	TO 12/31/2009	PART III
14-1327		

	TITLE XVIII PART A	HOSPITAL	OTHER
ART III - SKILLED NURSING FACILITY, NURSINGFACILITY & ICF/MR ONLY			1
66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST		
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM		
68	PROGRAM ROUTINE SERVICE COST		
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM		
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS		
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS		
72	PER DIEM CAPITAL-RELATED COSTS		
73	PROGRAM CAPITAL-RELATED COSTS		
74	INPATIENT ROUTINE SERVICE COST		
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS		
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION		
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		
78	INPATIENT ROUTINE SERVICE COST LIMITATION		
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS		
80	PROGRAM INPATIENT ANCILLARY SERVICES		
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION		
82	TOTAL PROGRAM INPATIENT OPERATING COSTS		

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	948
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,044.51
85	OBSERVATION BED COST	990,195

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
		1	2	3	4	5
86	OLD CAPITAL-RELATED COST					
87	NEW CAPITAL-RELATED COST					
88	NON PHYSICIAN ANESTHETIST					
89	MEDICAL EDUCATION					
89.01	MEDICAL EDUCATION - ALLIED HEA					
89.02	MEDICAL EDUCATION - ALL OTHER					

TITLE XIX - I/P HOSPITAL OTHER

ART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,864
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,465
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,465
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	362
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	37
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	113
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	37
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	90.00
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	90.00
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	90.00
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	90.00
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	32,580
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	3,330
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	3,015
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	-3,015
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,383,394
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,383,394
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.000891
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	976.45
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	-3,015

TITLE XIX - I/P HOSPITAL OTHER

\RT II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM				-	.87
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					-98
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM					
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					-98
		TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY)					
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43	INTENSIVE CARE UNIT		102		7	
44	CORONARY CARE UNIT					
45	BURN INTENSIVE CARE UNIT					
46	SURGICAL INTENSIVE CARE UNIT					
47	OTHER SPECIAL CARE					
						1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST					186,562
49	TOTAL PROGRAM INPATIENT COSTS					186,464

PASS THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	
52	TOTAL PROGRAM EXCLUDABLE COST	
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS	186,464

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES	40
55	TARGET AMOUNT PER DISCHARGE	
56	TARGET AMOUNT	
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	
58	BONUS PAYMENT	
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET	
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET	
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.	
58.04	RELIEF PAYMENT	
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT	
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)	
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1	
59.03	PROGRAM DISCHARGES AFTER JULY 1	
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)	
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)	
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)	
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)	
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)	

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	3,330
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS	3,330

TITLE XIX - I/P HOSPITAL OTHER

PART III - SKILLED NURSING FACILITY, NURSINGFACILITY & ICF/MR ONLY

		1
66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	
68	PROGRAM ROUTINE SERVICE COST	
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	
72	PER DIEM CAPITAL-RELATED COSTS	
73	PROGRAM CAPITAL-RELATED COSTS	
74	INPATIENT ROUTINE SERVICE COST	
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	
80	PROGRAM INPATIENT ANCILLARY SERVICES	
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	948
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	.87
85	OBSERVATION BED COST	-825

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
		1	2	3	4	5
86	OLD CAPITAL-RELATED COST					
87	NEW CAPITAL-RELATED COST					
88	NON PHYSICIAN ANESTHETIST					
89	MEDICAL EDUCATION					
89.01	MEDICAL EDUCATION - ALLIED HEA					
89.02	MEDICAL EDUCATION - ALL OTHER					

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1327	FROM 1/ 1/2009	WORKSHEET D-4
COMPONENT NO:	TO 12/31/2009	
14-1327		

TITLE XVIII, PART A HOSPITAL OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS		1,723,071	
26	INTENSIVE CARE UNIT		78,618	
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.281924	708,728	199,807
40	ANESTHESIOLOGY	.144393	8,176	1,181
41	RADIOLOGY-DIAGNOSTIC	.189642	366,568	69,517
44	LABORATORY	.189752	611,241	115,984
49	RESPIRATORY THERAPY	.427804	290,552	124,299
50	PHYSICAL THERAPY	.598416	124,314	74,391
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.569031	1,412,522	803,769
56	DRUGS CHARGED TO PATIENTS	.402444	976,870	393,135
59	ONCOLOGY	.813515		
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	.473140		
61	EMERGENCY	.645017	1,671	1,078
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.397091		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	TOTAL		4,500,642	1,783,161
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		4,500,642	

Health Financial Systems MCRIF32 FOR WABASH GENERAL HOSPITAL IN LIEU OF FORM CMS-2552-96(07/2009)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: 14-1327 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET D-4

I COMPONENT NO: 14-Z327 I

TITLE XVIII, PART A SWING BED SNF OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS			
26	INTENSIVE CARE UNIT			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.281924		
40	ANESTHESIOLOGY	.144393		
41	RADIOLOGY-DIAGNOSTIC	.189642	18,758	3,557
44	LABORATORY	.189752	40,225	7,633
49	RESPIRATORY THERAPY	.427804	41,881	17,917
50	PHYSICAL THERAPY	.598416	61,008	36,508
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.569031	36,526	20,784
56	DRUGS CHARGED TO PATIENTS	.402444	143,813	57,877
59	ONCOLOGY	.813515		
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	.473140		
61	EMERGENCY	.645017		
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.397091		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	TOTAL		342,211	144,276
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		342,211	

Health Financial Systems MCRIF32 FOR WABASH GENERAL HOSPITAL IN LIEU OF FORM CMS-2552-96(07/2009)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: 14-1327 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET D-4

I COMPONENT NO: 14-1327 I

TITLE XIX HOSPITAL OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS		222,351	
26	INTENSIVE CARE UNIT		4,450	
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.281924	125,756	35,454
40	ANESTHESIOLOGY	.144393	36,995	5,342
41	RADIOLOGY-DIAGNOSTIC	.189642	22,106	4,192
44	LABORATORY	.189752	43,134	8,185
49	RESPIRATORY THERAPY	.427804	25,720	11,003
50	PHYSICAL THERAPY	.598416	9,203	5,507
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.569031	148,266	84,368
56	DRUGS CHARGED TO PATIENTS	.402444	73,525	29,590
59	ONCOLOGY	.813515		
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	.473140		
61	EMERGENCY	.645017	4,528	2,921
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.397091		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC	.942815		
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	TOTAL		489,233	186,562
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		489,233	

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1327	FROM 1/ 1/2009	WORKSHEET E
COMPONENT NO:	TO 12/31/2009	PART B
14-1327		

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL
1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	4,811,644
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9,02) LINE 101.	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	4,811,644
	COMPUTATION OF LESSER OF COST OR CHARGES	
	REASONABLE CHARGES	
6	ANCILLARY SERVICE CHARGES	
7	INTERNS AND RESIDENTS SERVICE CHARGES	
8	ORGAN ACQUISITION CHARGES	
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
10	TOTAL REASONABLE CHARGES	
	CUSTOMARY CHARGES	
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).	
13	RATIO OF LINE 11 TO LINE 12	
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
17	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	4,859,760
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	CAH DEDUCTIBLES	31,308
18.01	CAH ACTUAL BILLED COINSURANCE LINE 17.01 (SEE INSTRUCTIONS)	1,990,606
19	SUBTOTAL (SEE INSTRUCTIONS)	2,837,846
20	SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
22	ESRD DIRECT MEDICAL EDUCATION COSTS	
23	SUBTOTAL	2,837,846
24	PRIMARY PAYER PAYMENTS	506
25	SUBTOTAL	2,837,340
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	296,515
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	296,515
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
28	SUBTOTAL	3,133,855
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
30	OTHER ADJUSTMENTS (SPECIFY)	
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
32	SUBTOTAL	3,133,855
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	2,331,231
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	802,624
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	
	TO BE COMPLETED BY CONTRACTOR	
50	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)	
51	OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)	
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY	
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)	
54	TOTAL (SUM OF LINES 51 AND 53)	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1327	FROM 1/ 1/2009	WORKSHEET E-1
COMPONENT NO:	TO 12/31/2009	
14-1327		

TITLE XVIII HOSPITAL

	DESCRIPTION			INPATIENT-PART A		PART B	
				MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
				1	2	3	4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				3,393,266		2,654,457
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.				NONE		NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)						
		ADJUSTMENTS TO PROVIDER	.01	8/14/2009	14,356	8/14/2009	58,404
		ADJUSTMENTS TO PROVIDER	.02	11/13/2009	275,215		
		ADJUSTMENTS TO PROVIDER	.03				
		ADJUSTMENTS TO PROVIDER	.04				
		ADJUSTMENTS TO PROVIDER	.05				
		ADJUSTMENTS TO PROGRAM	.50			11/13/2009	381,630
		ADJUSTMENTS TO PROGRAM	.51				
		ADJUSTMENTS TO PROGRAM	.52				
		ADJUSTMENTS TO PROGRAM	.53				
		ADJUSTMENTS TO PROGRAM	.54				
	SUBTOTAL		.99		289,571		-323,226
4	TOTAL INTERIM PAYMENTS				3,682,837		2,331,231
	TO BE COMPLETED BY INTERMEDIARY						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)						
		TENTATIVE TO PROVIDER	.01				
		TENTATIVE TO PROVIDER	.02				
		TENTATIVE TO PROVIDER	.03				
		TENTATIVE TO PROGRAM	.50				
		TENTATIVE TO PROGRAM	.51				
		TENTATIVE TO PROGRAM	.52				
	SUBTOTAL		.99		NONE		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER	.01		141,314		802,624
		SETTLEMENT TO PROGRAM	.02				
7	TOTAL MEDICARE PROGRAM LIABILITY				3,824,151		3,133,855

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

PROVIDER NO:	PERIOD:	PREPARED
14-1327	FROM 1/ 1/2009	WORKSHEET E-1
COMPONENT NO:	TO 12/31/2009	
14-Z327		

TITLE XVIII SWING BED SNF

	DESCRIPTION		INPATIENT-PART A MM/DD/YYYY 1	INPATIENT-PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			473,725		
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE		NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	ADJUSTMENTS TO PROVIDER	.01				
	ADJUSTMENTS TO PROVIDER	.02				
	ADJUSTMENTS TO PROVIDER	.03				
	ADJUSTMENTS TO PROVIDER	.04				
	ADJUSTMENTS TO PROVIDER	.05				
	ADJUSTMENTS TO PROGRAM	.50	11/13/2009	3,286		
	ADJUSTMENTS TO PROGRAM	.51				
	ADJUSTMENTS TO PROGRAM	.52				
	ADJUSTMENTS TO PROGRAM	.53				
	ADJUSTMENTS TO PROGRAM	.54				
	SUBTOTAL	.99		-3,286		NONE
4	TOTAL INTERIM PAYMENTS			470,439		
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	TENTATIVE TO PROVIDER	.01				
	TENTATIVE TO PROVIDER	.02				
	TENTATIVE TO PROVIDER	.03				
	TENTATIVE TO PROGRAM	.50				
	TENTATIVE TO PROGRAM	.51				
	TENTATIVE TO PROGRAM	.52				
	SUBTOTAL	.99		NONE		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01		53,169		
		SETTLEMENT TO PROGRAM .02				
7	TOTAL MEDICARE PROGRAM LIABILITY			523,608		

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

---

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1327	FROM 1/ 1/2009	
COMPONENT NO:	TO 12/31/2009	WORKSHEET E-2
14-Z327		

TITLE XVIII SWING BED SNF

	COMPUTATION OF NET COST OF COVERED SERVICES	PART A 1	PART B 2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	381,894	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	145,719	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	362	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	527,613	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	527,613	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	527,613	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	4,005	
14	80% OF PART B COSTS		
15	SUBTOTAL	523,608	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	523,608	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	470,439	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	53,169	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1327	FROM 1/ 1/2009	WORKSHEET E-3
COMPONENT NO:	TO 12/31/2009	PART II
14-1327		

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT
HOSPITAL

1	INPATIENT SERVICES	4,093,642
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	4,093,642
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	4,134,578
	COMPUTATION OF LESSER OF COST OR CHARGES	
	REASONABLE CHARGES	
7	ROUTINE SERVICE CHARGES	
8	ANCILLARY SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
10	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
	CUSTOMARY CHARGES	
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIA BLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
13	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	
14	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	4,134,578
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	386,355
21	EXCESS REASONABLE COST	
22	SUBTOTAL	3,748,223
23	COINSURANCE	
24	SUBTOTAL	3,748,223
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESS IONAL SERVICES (SEE INSTRUCTIONS)	75,928
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	75,928
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
26	SUBTOTAL	3,824,151
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVID ER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	3,824,151
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	3,682,837
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	141,314
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
	CURRENT ASSETS				
1	CASH ON HAND AND IN BANKS	2,002,628			
2	TEMPORARY INVESTMENTS	2,251,774			
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	8,256,569			
5	OTHER RECEIVABLES	190,523			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-3,809,840			
7	INVENTORY	502,202			
8	PREPAID EXPENSES				
9	OTHER CURRENT ASSETS	450,046			
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	9,843,902			
	FIXED ASSETS				
12	LAND				
12.01					
13	LAND IMPROVEMENTS				
13.01	LESS ACCUMULATED DEPRECIATION				
14	BUILDINGS	24,878,043			
14.01	LESS ACCUMULATED DEPRECIATION	-14,818,999			
15	LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT				
16.01	LESS ACCUMULATED DEPRECIATION				
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT				
18.01	LESS ACCUMULATED DEPRECIATION				
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	10,059,044			
	OTHER ASSETS				
22	INVESTMENTS				
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	650,087			
26	TOTAL OTHER ASSETS	650,087			
27	TOTAL ASSETS	20,553,033			

	LIABILITIES AND FUND BALANCE	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4
	CURRENT LIABILITIES				
28	ACCOUNTS PAYABLE	691,301			
29	SALARIES, WAGES & FEES PAYABLE	1,292,368			
30	PAYROLL TAXES PAYABLE				
31	NOTES AND LOANS PAYABLE (SHORT TERM)	312,081			
32	DEFERRED INCOME				
33	ACCELERATED PAYMENTS				
34	DUE TO OTHER FUNDS	925,091			
35	OTHER CURRENT LIABILITIES				
36	TOTAL CURRENT LIABILITIES	3,220,841			
	LONG TERM LIABILITIES				
37	MORTGAGE PAYABLE	5,805,000			
38	NOTES PAYABLE				
39	UNSECURED LOANS				
40.01	LOANS PRIOR TO 7/1/66				
40.02	ON OR AFTER 7/1/66				
41	OTHER LONG TERM LIABILITIES				
42	TOTAL LONG-TERM LIABILITIES	5,805,000			
43	TOTAL LIABILITIES	9,025,841			
	CAPITAL ACCOUNTS				
44	GENERAL FUND BALANCE	11,527,192			
45	SPECIFIC PURPOSE FUND				
46	DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47	DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48	GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49	PLANT FUND BALANCE-INVESTED IN PLANT				
50	PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51	TOTAL FUND BALANCES	11,527,192			
52	TOTAL LIABILITIES AND FUND BALANCES	20,553,033			

STATEMENT OF CHANGES IN FUND BALANCES

I PROVIDER NO: 14-1327 I PERIOD: I FROM 1/ 1/2009 I TO 12/31/2009 I PREPARED 5/20/2010 I WORKSHEET G-1

		GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4
1	FUND BALANCE AT BEGINNING OF PERIOD		10,333,490		
2	NET INCOME (LOSS)		1,193,702		
3	TOTAL		11,527,192		
	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
4	ADDITIONS (CREDIT ADJUSTM				
5					
6					
7					
8					
9					
10	TOTAL ADDITIONS				
11	SUBTOTAL		11,527,192		
	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
12	DEDUCTIONS (DEBIT ADJUSTM				
13					
14					
15					
16					
17					
18	TOTAL DEDUCTIONS				
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		11,527,192		

		ENDOWMENT FUND 5	6	PLANT FUND 7	8
1	FUND BALANCE AT BEGINNING OF PERIOD				
2	NET INCOME (LOSS)				
3	TOTAL				
	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
4	ADDITIONS (CREDIT ADJUSTM				
5					
6					
7					
8					
9					
10	TOTAL ADDITIONS				
11	SUBTOTAL				
	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
12	DEDUCTIONS (DEBIT ADJUSTM				
13					
14					
15					
16					
17					
18	TOTAL DEDUCTIONS				
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET				

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | PROVIDER NO: 14-1327 | PERIOD: FROM 1/ 1/2009 TO 12/31/2009 | PREPARED 5/20/2010 | WORKSHEET G-2 | PARTS I & II

PART I - PATIENT REVENUES

		REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
		GENERAL INPATIENT ROUTINE CARE SERVICES			
1	00	HOSPITAL	3,383,394		3,383,394
4	00	SWING BED - SNF			
5	00	SWING BED - NF			
9	00	TOTAL GENERAL INPATIENT ROUTINE CARE	3,383,394		3,383,394
		INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10	00	INTENSIVE CARE UNIT	100,938		100,938
15	00	TOTAL INTENSIVE CARE TYPE INPAT HOSP	100,938		100,938
16	00	TOTAL INPATIENT ROUTINE CARE SERVICE	3,484,332		3,484,332
17	00	ANCILLARY SERVICES	7,811,159	33,351,398	41,162,557
18	00	OUTPATIENT SERVICES			
18	50	RURAL HEALTH CLINIC		259,125	259,125
20	00	AMBULANCE SERVICES		1,169,316	1,169,316
24	00	PHYSICIAN	36,462	3,058,741	3,095,203
25	00	TOTAL PATIENT REVENUES	11,331,953	37,838,580	49,170,533

PART II-OPERATING EXPENSES

26	00	OPERATING EXPENSES		25,283,614
		ADD (SPECIFY)		
27	00	ADD (SPECIFY)		
28	00			
29	00			
30	00			
31	00			
32	00			
33	00	TOTAL ADDITIONS		
		DEDUCT (SPECIFY)		
34	00	DEDUCT (SPECIFY)	2,882,795	
35	00			
36	00			
37	00			
38	00			
39	00	TOTAL DEDUCTIONS		2,882,795
40	00	TOTAL OPERATING EXPENSES		22,400,819

STATEMENT OF REVENUES AND EXPENSES | PROVIDER NO: 14-1327 | PERIOD: FROM 1/ 1/2009 TO 12/31/2009 | PREPARED 5/20/2010 | WORKSHEET G-3

	DESCRIPTION	
1	TOTAL PATIENT REVENUES	49,170,533
2	LESS: ALLOWANCES AND DISCOUNTS ON	26,286,563
3	NET PATIENT REVENUES	22,883,970
4	LESS: TOTAL OPERATING EXPENSES	22,400,819
5	NET INCOME FROM SERVICE TO PATIENT	483,151
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUES	
7	INCOME FROM INVESTMENTS	
8	REVENUE FROM TELEPHONE AND TELEG	
9	REVENUE FROM TELEVISION AND RADI	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN S	
14	REVENUE FROM MEALS SOLD TO EMPLO	
15	REVENUE FROM RENTAL OF LIVING QU	
16	REVENUE FROM SALE OF MEDICAL & S TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OT	
18	REVENUE FROM SALE OF MEDICAL REC	
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS,FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	OTHER (SPECIFY)	1,042,555
24.01		
25	TOTAL OTHER INCOME	1,042,555
26	TOTAL	1,525,706
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	332,004
28		
29		
30	TOTAL OTHER EXPENSES	332,004
31	NET INCOME (OR LOSS) FOR THE PERIO	1,193,702

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1327	FROM 1/ 1/2009	WORKSHEET M-1
COMPONENT NO:	TO 12/31/2009	
14-8501		

RHC 1

		COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFICATION 4
	FACILITY HEALTH CARE STAFF COSTS				
1	PHYSICIAN				
2	PHYSICIAN ASSISTANT	54,369		54,369	
3	NURSE PRACTITIONER	22,400		22,400	
4	VISITING NURSE	37,665		37,665	
5	OTHER NURSE	429		429	
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	LABORATORY TECHNICIAN				
9	OTHER FACILITY HEALTH CARE STAFF COSTS				
10	SUBTOTAL (SUM OF LINES 1-9)	114,863		114,863	
	COSTS UNDER AGREEMENT				
11	PHYSICIAN SERVICES UNDER AGREEMENT				
12	PHYSICIAN SUPERVISION UNDER AGREEMENT				
13	OTHER COSTS UNDER AGREEMENT				
14	SUBTOTAL (SUM OF LINES 11-13)				
	OTHER HEALTH CARE COSTS				
15	MEDICAL SUPPLIES		1,291	1,291	
16	TRANSPORTATION (HEALTH CARE STAFF)				
17	DEPRECIATION-MEDICAL EQUIPMENT				
18	PROFESSIONAL LIABILITY INSURANCE				
19	OTHER HEALTH CARE COSTS				
20	ALLOWABLE GME COSTS				
21	SUBTOTAL (SUM OF LINES 15-20)		1,291	1,291	
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	114,863	1,291	116,154	
	COSTS OTHER THAN RHC/FQHC SERVICES				
23	PHARMACY				
24	DENTAL				
25	OPTOMETRY				
26	ALL OTHER NONREIMBURSABLE COSTS				
27	NONALLOWABLE GME COSTS				
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				
	FACILITY OVERHEAD				
29	FACILITY COSTS				
30	ADMINISTRATIVE COSTS	7,025	1,852	8,877	
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	7,025	1,852	8,877	
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	121,888	3,143	125,031	

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

PROVIDER NO:	PERIOD:	PREPARED
14-1327	FROM 1/ 1/2009	WORKSHEET M-1
COMPONENT NO:	TO 12/31/2009	
14-8501		

RHC 1

		RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
	FACILITY HEALTH CARE STAFF COSTS			
1	PHYSICIAN			
2	PHYSICIAN ASSISTANT	54,369		54,369
3	NURSE PRACTITIONER	22,400		22,400
4	VISITING NURSE	37,665		37,665
5	OTHER NURSE	429		429
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	LABORATORY TECHNICIAN			
9	OTHER FACILITY HEALTH CARE STAFF COSTS			
10	SUBTOTAL (SUM OF LINES 1-9)	114,863		114,863
	COSTS UNDER AGREEMENT			
11	PHYSICIAN SERVICES UNDER AGREEMENT			
12	PHYSICIAN SUPERVISION UNDER AGREEMENT			
13	OTHER COSTS UNDER AGREEMENT			
14	SUBTOTAL (SUM OF LINES 11-13)			
	OTHER HEALTH CARE COSTS			
15	MEDICAL SUPPLIES	1,291		1,291
16	TRANSPORTATION (HEALTH CARE STAFF)			
17	DEPRECIATION-MEDICAL EQUIPMENT			
18	PROFESSIONAL LIABILITY INSURANCE			
19	OTHER HEALTH CARE COSTS			
20	ALLOWABLE GME COSTS			
21	SUBTOTAL (SUM OF LINES 15-20)	1,291		1,291
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	116,154		116,154
	COSTS OTHER THAN RHC/FQHC SERVICES			
23	PHARMACY			
24	DENTAL			
25	OPTOMETRY			
26	ALL OTHER NONREIMBURSABLE COSTS			
27	NONALLOWABLE GME COSTS			
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)			
	FACILITY OVERHEAD			
29	FACILITY COSTS			
30	ADMINISTRATIVE COSTS	8,877		8,877
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	8,877		8,877
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	125,031		125,031

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

PROVIDER NO:	PERIOD:	PREPARED
14-1327	FROM 1/ 1/2009	5/20/2010
COMPONENT NO:	TO 12/31/2009	WORKSHEET M-2
14-8501		

RHC 1

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
	POSITIONS				
1	PHYSICIANS	.01	12	4,200	42
2	PHYSICIAN ASSISTANTS			2,100	
3	NURSE PRACTITIONERS	.68	3,355	2,100	1,428
4	SUBTOTAL (SUM OF LINES 1-3)	.69	3,367		1,470
5	VISITING NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	.69	3,367		
9	PHYSICIAN SERVICES UNDER AGREEMENTS				

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	116,154
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)	
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	116,154
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	1.000000
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)	8,877
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	119,276
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	128,153
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)	
18	SUBTRACT LINE 17 FROM LINE 16	128,153
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	128,153
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	244,307

		GREATER OF COL. 2 OR COL. 4 5
	POSITIONS	
1	PHYSICIANS	
2	PHYSICIAN ASSISTANTS	
3	NURSE PRACTITIONERS	
4	SUBTOTAL (SUM OF LINES 1-3)	3,367
5	VISITING NURSE	
6	CLINICAL PSYCHOLOGIST	
7	CLINICAL SOCIAL WORKER	
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	3,367
9	PHYSICIAN SERVICES UNDER AGREEMENTS	

(1) THE PRODUCTIVITY STANDARD FOR PHYSICIANS IS 4,200 AND 2,100 FOR ALL OTHERS. IF AN EXCEPTION TO THE STANDARD HAS BEEN GRANTED (WORKSHEET S-8, LINE 13 EQUALS "Y"), COLUMN 3, LINES 1 THRU 3 OF THIS WORKSHEET SHOULD BE BLANK. THIS APPLIES TO RHC ONLY.

CALCULATION OF REIMBURSEMENT SETTLEMENT
FOR RHC/FQHC SERVICES

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1327	FROM 1/ 1/2009	WORKSHEET M-3
COMPONENT NO:	TO 12/31/2009	
14-8501		

TITLE XVIII RHC 1

	DETERMINATION OF RATE FOR RHC/FQHC SERVICES	
1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	244,307
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	244,307
4	TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	3,367
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	3,367
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	72.56

		CALCULATION OF LIMIT (1)	
		PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)	999.00	999.00
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	72.56	72.56
	CALCULATION OF SETTLEMENT		
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		187
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)		13,569
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		
13	PROGRAM COVERED COSTS FROM MENTAL HEALTH SERVICES (LINE 9 X LINE 12)		
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (LINE 13 X 62.5%)		
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST (SEE INSTRUCTIONS)		
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLUMNS 1, 2 AND 3)*		13,569
16.01	PRIMARY PAYER AMOUNT		
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		692
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		12,877
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		10,302
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)		
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		10,302
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
23	OTHER ADJUSTMENTS (SPECIFY)		
24	NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)		10,302
25	INTERIM PAYMENTS		7,732
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		2,570
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2		

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDER YEAR PROVIDERS USE COLUMN 2 ONLY.

* FOR LINE 15, USE COLUMN 2 ONLY FOR GRADUATE MEDICAL EDUCATION PASS THROUGH COST.

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES
[X] RHC [ ] FQHC

PROVIDER NO:	PERIOD:	PREPARED 5/20/2010
14-1327	FROM 1/ 1/2009	WORKSHEET M-5
COMPONENT NO:	TO 12/31/2009	
14-8501		

RHC 1

	DESCRIPTION			PART B MM/DD/YYYY 1	AMOUNT 2
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				7,732
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.				NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
		ADJUSTMENTS TO PROVIDER	.01		
		ADJUSTMENTS TO PROVIDER	.02		
		ADJUSTMENTS TO PROVIDER	.03		
		ADJUSTMENTS TO PROVIDER	.04		
		ADJUSTMENTS TO PROVIDER	.05		
		ADJUSTMENTS TO PROGRAM	.50		
		ADJUSTMENTS TO PROGRAM	.51		
		ADJUSTMENTS TO PROGRAM	.52		
		ADJUSTMENTS TO PROGRAM	.53		
		ADJUSTMENTS TO PROGRAM	.54		
	SUBTOTAL		.99		NONE
4	TOTAL INTERIM PAYMENTS				7,732
	TO BE COMPLETED BY INTERMEDIARY				
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
		TENTATIVE TO PROVIDER	.01		
		TENTATIVE TO PROVIDER	.02		
		TENTATIVE TO PROVIDER	.03		
		TENTATIVE TO PROGRAM	.50		
		TENTATIVE TO PROGRAM	.51		
		TENTATIVE TO PROGRAM	.52		
	SUBTOTAL		.99		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER	.01		2,570
		SETTLEMENT TO PROGRAM	.02		
7	TOTAL MEDICARE PROGRAM LIABILITY				10,302

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.